

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17004

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

|   |                                  |   |  |   |  |   |  |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural - Boonsboro</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>21 yrs</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Boonsboro</u>                                    |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Fabney-Keedy Home</u>  |                                  |   |  | d. STREET ADDRESS<br><u>Boonsboro, Md</u>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>First</u> <u>Ruth</u> <u>Middle</u> <u>Albert</u> <u>Last</u>   |                                  |   |  | 4. DATE OF DEATH <u>December</u> <u>13</u> <u>1965</u>  |  |   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 28, 1896</u> | 9. AGE (In years last birthday)<br><u>68 yrs.</u>   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>none</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Washington, Md</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Nathan M. Albert</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Margaret H. Bloom</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>no</u>  |  | 17. INFORMANT<br><u>Record at Fabney-Keedy -</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>492X</u> <u>Acute pneumonia</u><br>DUE TO (b) <u>Dislocation of right hip -</u><br>DUE TO (c) <u>  </u>   |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 weeks</u><br><u>10 weeks</u>                             |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 16</u> , 19 <u>65</u> , to <u>Dec 13</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 13</u> , 19 <u>65</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above. |                                  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><u>E. W. LeVan</u>  |                                  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |  | 22b. DATE SIGNED<br><u>12-14-65</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>E. W. LeVan</u>  |                                  |   |  | 22d. ADDRESS<br><u>Boonsboro, Md</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>Dec 15, 1965</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Westminster Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Westminster, Md.</u>                           |  |
| 24. FUNERAL DIRECTOR<br><u>J. E. Smyers, Jr.</u>  |                                  |   |  | ADDRESS<br><u>Westminster, Md</u>   |  | 25a. REC'D BY REGISTRAR<br><u>DEC 20 1965</u>   |  |
|   |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>   |  |   |  |

2032

20071



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17005

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

20388

|   |                                  |   |  |   |   |   |   |
|---|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |   |   |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>1 week</u>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Rural Williamsport RFD #2</u>                          |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Washington County Hospital</u>   |                                  |   |  | d. STREET ADDRESS<br><u>1 Hagerstown Pike</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>David</u> Middle <u>Charles</u> Last <u>Anderson</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>12</u> Year <u>1965</u> |   |   |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 19 1891</u>                             |   | 9. AGE (In years last birthday)<br><u>74</u> yrs. | IF UNDER 1 YEAR<br>Months <u>2</u> Days <u>22</u>   | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Leather Finisher</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Tannery</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Williamsport Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |   |
| 13. FATHER'S NAME<br><u>Omer W. Anderson</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Ella Ridenour</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>215 09 7400</u>   |  | 17. INFORMANT<br><u>Mrs. Bessie Anderson</u>  |   | Address <u>Williamsport Md. RFD #2</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br><u>4201</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial failure</u><br>DUE TO (c) <u>Generalized arteriosclerosis</u> |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>exogenous obesity</u>  |                                  |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>none</u>   |  |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>none</u> p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>none</u>   |   | 20f. (City or town) (County) (State)<br><u>- - -</u>  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>63</u> , to <u>Dec 12</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 11</u> , 19 <u>65</u> , and that death occurred at <u>A</u> M, from the causes and on the date stated above.  |                                  |   |  |   |   |   |   |
| 22a. SIGNATURE<br><u>Harold R. Tritch, Jr</u>   |                                  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |   | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Harold R. Tritch, Jr M.D</u>   |                                  |   |  | 22d. ADDRESS<br><u>302 N. Potomac Street Hagerstown, Md</u>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>Dec. 15-65</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rest Haven Cemetery</u>  |   | 23d. LOCATION (City, town or county) (State)<br><u>Hagerstown Maryland</u>                        |   |
| 24. FUNERAL DIRECTOR<br><u>Albert L. Leaf Williamsport Md.</u>  |                                  |   |  | ADDRESS<br><u>DEC 15 1965</u>   |   | 25. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |

22303

15003

Generalized symptoms  
muscular fatigue  
acute respiratory infection

exposure of skin

none

none

none

11

11

*[Handwritten signature]*

From A. L. Litchfield, M.D.

503 N. Lombard Street, St. Louis, Mo.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

17006

Item #2d Film #4312 1/14/66 pg

20389

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>  |   | d. STREET ADDRESS <u>931 Main Ave.</u><br><u>Coffman Home for the Aged</u>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>LUELLA ANNA ANDERSON</u>  |   | 4. DATE OF DEATH Month Day Year<br><u>Dec. 25 19 65</u>  |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 11-1876</u>  |
| 9. AGE (In years last birthday) <u>89</u> yrs.  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Leitersburg Wash Co Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>Mayberry Freed</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Cietta H. Stouffer</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |   | 16. SOCIAL SECURITY NO. <u>none</u>  |   |
| 17. INFORMANT <u>Mrs. Edna Brandenburg</u>  |   | Address <u>320 No. Locust</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pulmonary edema + congestive failure</u><br>4200 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u><br>DUE TO (c) |   | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u><br><u>years</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus and fractured hip</u>  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>Dec 25, 19 65</u> , that (I) (we) last saw the deceased alive on <u>Dec 25 19 65</u> , and that death occurred at _____ M, from the causes and on the date stated above.   |   |  |   |
| 22a. SIGNATURE <u>John C. Stauffer</u>  |   | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M. D.</u>   |   | 22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF <u>12-28-65</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>  | 23d. LOCATION (City, town or county) (State) <u>Leitersburg Wash Co Md/</u> |
| 24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>   |   | 25a. REC'D BY REGISTRAR <u>DEC 30 1965</u>   |   |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                  |   |   |  |   |  |  |  |
|--|--|----------------------------------|---|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |                                  |   |   |  |   |  |  |  |
| 17007 21290  |  |                                  |   |   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b<br><b>3 Days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington County Hospital</b>  |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Boonsboro</b><br>d. STREET ADDRESS<br><b>Lakin Ave. Ext.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Eleanor Virginia Ashkettle</b>   |  |                                  | First Middle Last   |   | 4. DATE OF DEATH<br><b>December 30, 1965</b>   |   | Month Day Year   |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 29, 1923</b> |  | 9. AGE (In years last birthday)<br><b>42</b> yrs. Months <b>9</b> Days <b>1</b> Hours <b></b> Min. <b></b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Smithsburg, Md.</b>  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>Maurice Bowman</b>   |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Naomi Bowman</b>  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No.</b>  |  |                                  | 16. SOCIAL SECURITY NO.<br><b>219-12-2018</b>   |   | 17. INFORMANT<br><b>James E. Ashkettle, Boonsboro, Md.</b>   |   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Breast</b><br>170X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastasis to Liver + Lung</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                  |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 yrs</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>27 Dec, 1965</b> , to <b>30 Dec, 1965</b> , that (I) (we) last saw the deceased alive on <b>30 Dec 1965</b> , and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above.   |  |                                  |   |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Frank E. Brumback</b>   |  |                                  |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   | 22b. DATE SIGNED<br><b>31 Dec 65</b>                                   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Frank E Brumback</b>  |  |                                  |   |   | 22d. ADDRESS<br><b>119 King St Hagerstown</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  | 23b. DATE THEREOF<br><b>1-2-66</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>Hagerstown, Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>  |  |                                  |   |   | ADDRESS  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 4 1966</b>                           |  |  |
|  |  |                                  |   |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                   |  |  |

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Washington

Washington

Washington

Washington

Washington County Hospital

Washington Ave. Inc.

Albany

Albany

Female White

March 22, 1937

Lawrence

Lawrence

Lawrence

Lawrence

214-12-2013

March 22, 1937

March

March

March

March 22, 1937

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17008

20391

|   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>e. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> <span style="float: right;">c. LENGTH OF STAY IN 1b</span><br><u>60yrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>41 W. Bethel Street</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Washington</u></span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>03 Hagerstown Maryland</u><br>d. STREET ADDRESS<br><u>41 W. Bethel Street</u> <span style="float: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span> |  |   |  |   |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Mary</u> <span style="float: right;">First</span><br><u>Winifred</u> <span style="float: right;">Middle</span><br><u>Barnum</u> <span style="float: right;">Last</span>  |  | <b>4. DATE OF DEATH</b><br><u>Dec</u> <span style="float: right;">Month</span><br><u>25</u> <span style="float: right;">Day</span><br><u>19 65</u> <span style="float: right;">Year</span> |  | <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>Colored</u>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <span style="float: right;">b. DATE OF BIRTH</span><br><u>WIDOWED</u> <input checked="" type="checkbox"/> <u>Divorced</u> <input type="checkbox"/> <u>May 10 1875</u> |  | <b>9. AGE</b> (In years last birthday) <u>90</u> <span style="float: right;">yrs.</span><br><b>IF UNDER 1 YEAR</b> <span style="float: right;">Months</span> <span style="float: right;">Days</span><br><b>IF UNDER 24 HRS.</b> <span style="float: right;">Hours</span> <span style="float: right;">Min.</span> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Own home</u>   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Paris, Va.</u>                                   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA.</u>  |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>Joshua Gaskin</u>  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Caroline Boas</u>   |  |   |  |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <span style="float: right;">(If yes give war or dates of service)</span>   |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>none</u>   |  | <b>17. INFORMANT</b> <span style="float: right;">Address</span><br><u>Mrs. Carrie Barnum 58 W. Bethel St.</u>     |  |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u><br><u>4201</u> <span style="float: right;">DUE TO</span><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="float: right;">(b)</span> <u>ARTERIOSCLEROTIC HEART DISEASE</u><br><span style="float: right;">(c)</span> <u>ARTERIOSCLEROSIS, GENERALIZED</u> |  |  |  |   |  |   |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>SEVERAL</u><br><u>Yes.</u><br><u>Yes.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <span style="float: right;">OR CONTRIBUTING <input type="checkbox"/> <span style="float: right;">CAUSE OF DEATH</span><br/>                 (IF EITHER, NOTIFY MEDICAL EXAMINER)             </span>   |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> <span style="float: right;">Month, Day, Year</span><br>Hour a.m. <span style="float: right;">p.m.</span><br>19   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> <span style="float: right;">(County)</span> <span style="float: right;">(State)</span> |  |   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>27 Sept., 1963</u> <span style="float: right;">to</span> <u>25 Dec., 1965</u> , that (I) (we) last saw the deceased alive on <u>7 Dec., 1965</u> , and that death occurred at <u>7:42 AM</u> , from the causes and on the date stated above.  |  |  |  |   |  |   |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>[Signature]</u> <span style="float: right;">M.D.</span>   |  |  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <span style="float: right;">MED. DIRECTOR</span> <input type="checkbox"/> <span style="float: right;">STAFF PHYS. <input type="checkbox"/> </span>   |  | <b>22b. DATE SIGNED</b><br><u>27 Dec. 1965</u>  |  |   |  |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>W. N. FENDER</u>  |  |  |  | <b>22d. ADDRESS</b><br><u>218 N. Potomac St., Hagerstown, Md.</u>   |  |   |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>12-29-1965</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Rose Hill Cemetery</u>  |  | <b>23d. LOCATION</b> (City, town or county) <span style="float: right;">(State)</span><br><u>Hagerstown Md.</u>   |  |   |  |  |  |
| <b>24 FUNERAL DIRECTOR'S SIGNATURE</b><br><u>[Signature]</u> <span style="float: right;">ADDRESS</span><br><u>Hagerstown Md.</u>  |  |  |  | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 29 1965</u>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>[Signature]</u>   |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

251



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

17009

20392

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b>  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Near Hagerstown</b>   |   |   | c. LENGTH OF STAY IN 1b<br><b>2Yr. 9Mo.</b>   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Homewood Church Home</b>  |   |   | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>                                      |   |  |
| f. STREET ADDRESS<br><b>44 East Antietam</b>   |   |   | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Emma</b> Middle <b>Florence</b> Last <b>Binkley</b>  |   |   | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>18</b> Year <b>1965</b>  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 2, 1883</b>  | 9. AGE (In years last birthday)<br><b>83 yrs.</b>       | IF UNDER 1 YEAR<br>Months <b>03</b> Days <b>15</b> Hours <b>00</b> Min. <b>00</b>      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Middleburg Penna.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |
| 13. FATHER'S NAME<br><b>John Layman</b>  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Amelia Zeigler</b>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br><b>Mrs Roy J. McNamee</b> Address <b>40 East Antietam St Hagerstown, Md</b>  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Dis.</b><br><b>4200</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c) |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs.</b>                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)  | (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8-15</b> , 19 <b>65</b> , to <b>12-18</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12-15</b> 19 <b>65</b> , and that death occurred at <b>3:15</b> A.M., from the causes and on the date stated above.              |   |   |   |   |  |
| 22a. SIGNATURE<br><b>Robert P. Conrad</b>  |   |   | 22b. DATE SIGNED<br><b>12-18-65</b>   | 22c. PHYSICIAN'S NAME (Type)<br><b>Robert P. Conrad</b> |  |
| 22d. ADDRESS<br><b>137 W. Washington Hagerstown, Md</b>  |   |   | 22e. REC'D BY REGISTRAR<br><b>DEC 22 1965</b>   |   |  |
| 22f. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |   |   | 22g. NAME OF CEMETERY OR CREMATORY<br><b>Reformed Cemetery</b>  |   |  |
| 22h. LOCATION (City, town or county)<br><b>Middleburg Penna.</b>   |   |   | 22i. STATE<br><b>Penna.</b>   |   |  |
| 22j. FUNERAL DIRECTOR<br><b>Andrew K. Coffman</b>  |   |   | 22k. ADDRESS<br><b>Hagerstown, Maryland</b>   |   |  |

90303

12003

CERTIFICATE OF DEATH

STATE OF NEW YORK

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX AND COLOR

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PROPERTY

DEBTS

ESTATE

WILLS

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17010  
20392  
CERTIFICATE OF DEATH

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b<br><b>8 MOS.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>444 W. FRANKLIN STREET</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b><br>d. STREET ADDRESS<br><b>343 W. WASHINGTON STREET</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>HELVA VIOLA BLACK</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>DECEMBER 9 19 65</b>  |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>APRIL 8, 1914</b> |
| 9. AGE (In years last birthday)<br><b>51 yrs.</b>   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TAVERN OWNER</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>TAVERN</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>WASHINGTON CO., MARYLAND</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>ROBERT L. FOX</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>ANNA E. WERDEBAUGH</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>213-18-9129</b>  |  |
| 17. INFORMANT<br><b>MR. CODY BLACK, SR.</b>   |                                  | Address<br><b>HAGERSTOWN, MD.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of esophagus--epithelial type</b><br>150X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Malnutrition</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 28</b> , 19 <b>64</b> , to <b>Dec. 9</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec. 9</b> , 19 <b>65</b> , and that death occurred at <b>5:15 M.</b> from the causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><i>W. T. Layman</i><br>22c. PHYSICIAN'S NAME (Type)<br><b>WILLIAM T. LAYMAN M.D.</b>  |                                  | 22b. DATE SIGNED<br><b>12/10/1965</b><br>22d. ADDRESS<br><b>PROFESSIONAL ARTS BLDG. HAGERSTOWN</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>DEC. 13, 1965</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>ROSE HILL CEMETERY</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>HAGERSTOWN, MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR<br><i>Charles M. Rouse</i><br><b>HAGERSTOWN, MARYLAND</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 16 1965</b><br>25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |

10/10/65

10/10/65

WASHINGTON

MARYLAND

WASHINGTON

WASHINGTON

8 Nov.

WASHINGTON

303 N. WASHINGTON STREET

104 N. WASHINGTON STREET

WASHINGTON

BLACK

WHITE

WHITE

WHITE

WHITE

WASHINGTON CO., MARYLAND

TAKEN

TAKEN

ANNAPOLIS, MARYLAND

ROBERT L. FOL

WASHINGTON CO., MARYLAND

NO

WASHINGTON CO., MARYLAND

WASHINGTON

WASHINGTON

10/10/65

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |   |                                   |  |  |
|--|--|---|--|---|--|---|-----------------------------------|--|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |                                   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b>   |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>     |  | c. LENGTH OF STAY IN 1b<br><b>40 years</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |                                   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington County Hospital</b>  |  |   |  |   |  | d. STREET ADDRESS<br><b>1 55 E. Franklin St.</b>  |                                   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FLORENCE</b> Middle <b>ISABELL</b> Last <b>BOWARD</b>  |  |   | 4. DATE OF DEATH<br>Month <b>Dec</b> Day <b>18</b> Year <b>19 65</b> |   |  |   |                                   |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>June 28, 1897</b>  |                                   | 9. AGE (In years last birthday) <b>68</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Chambersburg, Pa.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?  |                                   |  |  |
| 13. FATHER'S NAME<br><b>George Lippy</b>   |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Martha Brough</b> |   |                                   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |  | 17. INFORMANT<br><b>Mrs. William Boward</b>   |  |   | Address<br><b>Hagerstown, Md.</b> |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Complete Heart Block</b><br>DUE TO (b) <b>Myocardial infarct</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>moderately advanced arteriosclerotic heart disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>none</b> |  |   |  |   |  |   |                                   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>None</b>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)              |  |   |  |   |                                   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>none</b> p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>none</b>   |  | 20f. (City or town) (County) (State)<br><b>- - -</b>  |                                   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>61</b> , to <b>Dec 18</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec 17</b> , 19 <b>65</b> , and that death occurred at <b>A.M.</b> , from the causes and on the date stated above.   |  |   |  |   |  |   |                                   |  |  |
| 22a. SIGNATURE<br><b>Dr Harold R. Tritch, Jr</b>   |  |   |  |   |  |   |                                   | 22b. DATE SIGNED<br><b>12-20-65</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)   |  | 22d. ADDRESS  |  | 22e. REC'D BY REGISTRAR   |  | 22f. REGISTRAR'S SIGNATURE  |                                   |  |  |
| <b>Scot F. Minnich &amp; Son</b>   |  | <b>Hagerstown, Md.</b>  |  | <b>DEC 27 1965</b>  |  | <b>Charles Judge</b>  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>12-21-65</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Lawn Gardens</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Hagerstown, Md.</b>  |                                   |  |  |

1975-1976

37-18-31-123-201-1



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

20395

|   |                                  |   |   |   |   |   |  |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pinesburg Md.</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>16 Years</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pinesburg Md.</b>                                      |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>Rd. 2</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>William Thorle Brant</b>   |                                  |   |   | 4. DATE OF DEATH <b>Dec. 1, 65</b> 19 <b>65</b>   |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct 11, 1912</b> |   | 9. AGE (In years last birthday)<br><b>53</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Months Days Hours Min.           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Furniture</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 13. FATHER'S NAME<br><b>William R. Brant</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Lula Downs XXXXX</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>214-09-2576</b>  |   | 17. INFORMANT<br><b>Arlene Brant Pinesburg Md.</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b><br>4201 DUE TO<br>Coronary artery occlusion with myocardial infarction 5 minutes<br>(b) <b>Coronary artery atherosclerosis</b><br>DUE TO<br>unknown<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Tumor, middle lobe, lung, right, undiagnosed type of tumor</b> |                                  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Feb. 8, 1963</b> , 19 <b>63</b> , to <b>December 1, 1965</b> , that I last saw the deceased alive on <b>Nov. 22, 1965</b> , 19 <b>65</b> , and that death occurred at <b>7:55 PM</b> , from the causes and on the date stated above.   |                                  |   |   |   |   |   |  |
| ACTUAL SIGNATURE <b>Archie Robert Cohen</b>   |                                  |   |   | ADDRESS (Street, city or town, state) <b>P.O. Box 205</b> DATE SIGNED <b>12/03/65</b>   |   |   |  |
| PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>  |                                  |   |   | Clear Spring, Maryland  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Dec 4, 65</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Green Lawn</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Williamsport Md.</b>                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Donald E. Thompson</b>   |                                  |   |   | ADDRESS<br><b>Clear Spring, Md.</b>   |   | 24a. REC'D BY REGISTRAR <b>DEC 8 1965</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove cap and papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10552

Page Two of Two

15

|  |  |  |  |
|--|--|--|--|
| <p>1. Name of deceased: <b>James Earl Ray</b></p>                |  | <p>2. Date of birth: <b>May 17, 1928</b></p>                               |  |
| <p>3. Sex: <b>Male</b></p>                                       |  | <p>4. Race: <b>White</b></p>   |  |
| <p>5. Usual residence: <b>Room 10, Box 1, St. Louis, Mo.</b></p> |  | <p>6. Date of death: <b>May 17, 1968</b></p>                               |  |
| <p>7. Place of death: <b>St. Louis, Mo.</b></p>                  |  | <p>8. Cause of death: <b>Gunshot wound, right chest, entrance only</b></p> |  |
| <p>9. Manner of death: <b>Accident</b></p>                       |  | <p>10. Physician's signature: <b>James Earl Ray</b></p>                    |  |
| <p>11. Signature of informant: <b>James Earl Ray</b></p>         |  | <p>12. Signature of registrar: <b>James Earl Ray</b></p>                   |  |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 20396

17013

|   |                              |   |  |   |   |   |                  |
|---|------------------------------|---|--|---|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> <b>MARYLAND</b>  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>2 weeks</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural - Fayetteville 75X-3</u>                     |   |   |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Washington Co. Hospital</u>  |                              |   |  | d. STREET ADDRESS   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle <u>Henry</u> Last <u>Brookens</u>  |                              |   |  | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>16</u> Year <u>1965</u>   |   |   |                  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 11, 1885</u> |   | 9. AGE (In years lost birthday)<br><u>80</u> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired laborer</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>masonry</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Penna.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |                  |
| 13. FATHER'S NAME<br><u>Joseph Brookens</u>   |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Jennie West</u>  |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><u>no</u>  |                              | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><u>192-30-1279</u>   |  | 17. INFORMANT<br>Address <u>Mr. &amp; Mrs. Clara P. Brookens, Fayetteville, Pa.</u>   |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Azotemia</u><br><u>180X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma left kidney</u> DUE TO<br>(c) <u>Secondary anemia, severe</u> |                              |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>several months</u>                        |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary anemia, severe</u>   |                              |   |  |   |   |   |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that I attended the deceased from <u>Nov 30, 1965</u> , to <u>Dec 16, 1965</u> , that I last saw the deceased alive on <u>Dec 15, 1965</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.   |                              |   |  |   |   |   |                  |
| ACTUAL SIGNATURE<br><u>Joseph B. Crisp</u>  |                              |   |  | ADDRESS (Street, city or town, state)<br><u>580 Northern ave</u>  |   |   |                  |
| PHYSICIAN'S NAME (Type)<br><u>JOS. C. CRISP.</u>  |                              |   |  | DATE SIGNED<br><u>Hagerstown MD</u>   |   |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              | 22b. DATE THEREOF<br><u>12/19/65</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Pleasant</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Franklin Co., Pa.</u>                         |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert P. Barbour, Chambersburg, Pa.</u>   |                              |   |  | 24a. REC'D BY REGISTRAR<br><u>DEC 21 1965</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>   |                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                            |  |                          |  |                           |  |                              |  |                        |  |                         |  |                               |  |                               |  |
|----------------------------|--|--------------------------|--|---------------------------|--|------------------------------|--|------------------------|--|-------------------------|--|-------------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED        |  | 2. SEX                   |  | 3. AGE                    |  | 4. RACE                      |  | 5. DATE OF BIRTH       |  | 6. PLACE OF BIRTH       |  | 7. DATE OF DEATH              |  | 8. PLACE OF DEATH             |  |
| JAMES H. HARRIS            |  | Male                     |  | 45                        |  | White                        |  | 1910                   |  | Maryland                |  | 1955                          |  | Baltimore, Maryland           |  |
| 9. OCCUPATION              |  | 10. CAUSE OF DEATH       |  | 11. MANNER OF DEATH       |  | 12. MEDICAL HISTORY          |  | 13. PRESENT ILLNESS    |  | 14. TREATMENT           |  | 15. POST-MORTEM               |  | 16. SIGNATURE OF PHYSICIAN    |  |
| None                       |  | Heart Disease            |  | Natural                   |  | None                         |  | None                   |  | None                    |  | None                          |  | None                          |  |
| 17. SIGNATURE OF REGISTRAR |  | 18. SIGNATURE OF WITNESS |  | 19. SIGNATURE OF DECEASED |  | 20. SIGNATURE OF NEXT OF KIN |  | 21. SIGNATURE OF CLERK |  | 22. SIGNATURE OF CHURCH |  | 23. SIGNATURE OF FUNERAL HOME |  | 24. SIGNATURE OF BURIAL PLACE |  |
| None                       |  | None                     |  | None                      |  | None                         |  | None                   |  | None                    |  | None                          |  | None                          |  |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE FUNERAL HOME AND THE BURIAL PLACE.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17014

20397

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Garlock Memorial Convalescent Home</b>   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>d. STREET ADDRESS <b>111 South Market Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>First Middle Last</b><br><b>ELIZABETH REBECCA Brown</b>   |  |   | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>4</b> Year <b>19 65</b>   |  |   |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 8. DATE OF BIRTH <b>18 Jan 1897</b>   |  | 9. AGE (In years last birthday) <b>68</b> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Frederick, Md.</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>   |  |   | 13. FATHER'S NAME <b>Albert R. Wallis</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME <b>Fannie A. Shipley</b>   |  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b><br>(If yes give war or dates of service)   |  |   |
| 16. SOCIAL SECURITY NO. <b>046-03-9205</b>  |  |   | 17. INFORMANT Address <b>Forrest N. Brown (Same as item #2)</b>  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br><b>331X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis (cerebral)</b><br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b><br><br><b>Indefinite</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 29</b> , 19 <b>65</b> to <b>Dec. 4</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec. 3</b> , 19 <b>65</b> and that death occurred at <b>6:05 A.</b> M, from the causes and on the date stated above.  |  |   |  |  |   |
| 22a. SIGNATURE <b>B. B. Kneisley</b>  |  |   | 22b. DATE SIGNED <b>Dec. 4, 1965</b>   |  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>  |  |   | 22d. ADDRESS <b>148 West Washington St. Hagerstown, Maryland</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>12/7/65</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>  |   |
| 23d. LOCATION (City, town or county) <b>Frederick, Md.</b>  |  | 23e. (State) <b>21701</b>   |  |  |   |
| 24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md.</b>  |  |   | 25a. REC'D BY REGISTRAR <b>DEC 7 1965</b>  |  |   |
| 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |   |  |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50307

1716

Pres. H. H.

Pres. H. H.

Pres. H. H.

Pres. H. H.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |   |  |  |  |  |  |  |   |
|---|--|-------------------------------|---|--|--|--|--|--|--|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |   |  |  |  |  |  |  |   |
| CERTIFICATE OF DEATH  |  |                               |   |  |  |  |  |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>11 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>  |  |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b><br>d. STREET ADDRESS <b>104 N. CLEVELAND AVENUE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LOUELLA</b> Middle <b>AUGUSTIES</b> Last <b>BROWN</b>   |  |                               | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>20</b> Year <b>19 65</b>                                 |  |  |  |  |  |  |   |
| 5. SEX <b>FEMALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b> |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>JULY 17, 1881</b>                                    |  | 9. AGE (In years last birthday) <b>84</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>  |  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>   |  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>UNKNOWN, OHIO</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |
| 13. FATHER'S NAME <b>MARTIN L. MOATS</b>  |  |                               |   |  | 14. MOTHER'S MAIDEN NAME <b>SARA GRIMM</b>   |  |  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  |                               | 16. SOCIAL SECURITY NO. <b>NONE</b>   |  | 17. INFORMANT <b>HAGERSTOWN, MARYLAND</b><br><b>MISS. MARGARET BIERLEY 104 N. CLEVELAND AV.</b>  |  |  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b><br>DUE TO (c) <b>generalized arteriosclerosis</b> |  |                               |   |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |                               |   |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |  |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/11</b> , 19 <b>65</b> to <b>12/20</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12/20/65</b> 19 <b>65</b> , and that death occurred at <b>11:22</b> M, from the causes and on the date stated above.   |  |                               |   |  |  |  |  |  |  |   |
| 22a. SIGNATURE <b>Robert V. Campbell</b> M.D.   |  |                               |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED <b>DEC. 21, 1965</b>                                    |  |  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>ROBERT V. CAMPBELL M.D.</b>   |  |                               |   |  | 22d. ADDRESS <b>145 W. WASHINGTON ST. HAGERSTOWN, MD.</b>  |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |                               | 23b. DATE THEREOF <b>DEC. 23, 1965</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>   |  | 23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b> |  |  |   |
| 24. FUNERAL DIRECTOR <b>Charles Judge</b> ADDRESS <b>HAGERSTOWN, MARYLAND</b>   |  |                               |   |  | 25a. REC'D BY REGISTRAR <b>DEC 28 1965</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                          |  |  |   |

30508

WASHINGTON

MARYLAND

WASHINGTON

WASHINGTON

11 DAYS

WASHINGTON

100 N. CLEVELAND AVENUE

WASHINGTON COUNTY HOSPITAL

NOV 25

DECEMBER 10

BROWN

ADJUSTED

LABELLA

AT

JULY 19, 1981

BY

WHITE

WHITE

0.0.0.

OHIO

UNKNOWN

OWN HOME

NONPAYER

SALV. 3000

MARTIN I. MOY

WASHINGTON, MARYLAND

MRS. MARGARET ELLIOTT 100 N. CLEVELAND W.

HOME

NO

DEC. 21, 1982

WASHINGTON, MD.

105 N. WASHINGTON ST.

ROBERT V. CAMPBELL, D.D.

MARYLAND

WASHINGTON

DEC. 23, 1982

RECEIVED

WASHINGTON, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |  |   |  |  |   |  |
|--|--|---|--|--|---|--|--|---|--|
| 17016  |  |   |  |  | 20399   |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Washington</u> MARYLAND   |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |  |   | c. LENGTH OF STAY IN 1b<br><u>10 days</u>                            |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>13 Hagerstown</u>                                      |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Washington County Hospital</u>  |  |   |  |  | d. STREET ADDRESS<br><u>31 1/2 E. Franklin St</u>   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>RAY</u> Middle <u>L.</u> Last <u>BUHRMAN</u>   |  |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>21</u> Year <u>1965</u> |  |   |  |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>May 4, 1896</u>                               |  | 9. AGE (in years last birthday)<br><u>69 yrs.</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Painter</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Smithsburg, Wash Cty, Md</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>                         |  |   |  |
| 13. FATHER'S NAME<br><u>Emory L. Buhrman</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ella Kendall</u>  |   |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |  | 16. SOCIAL SECURITY NO.<br><u>206-03-5147</u>   |  | 17. INFORMANT<br><u>Mrs. Leon Delauter, R # 1, Clearspring, Md.</u>  |   |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>pulmonary emboli &amp; arterial emboli</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure</u><br>(c) <u>arteriosclerotic heart disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |   |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>days</u><br><u>weeks</u><br><u>years</u>                   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                 |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 15, 1965</u> , to <u>Dec 21, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 20, 1965</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.  |  |   |  |  |   |  |  |   |  |
| 22a. SIGNATURE<br><u>John C. Stauffer</u>  |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |   | 22b. DATE SIGNED   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>John C. Stauffer</u>  |  |   |  | 22d. ADDRESS<br><u>145 S. Prospect St.</u>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>12/24/65</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Bethel Cemetery</u>   |   | 23d. LOCATION (City, town or county) (State)<br><u>Garfield, Md.</u> |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Andrew K. Doffman Funeral Home, Inc</u><br><u>Hagerstown, Md.</u>   |  |   |  | 25a. REC'D BY REGISTRAR<br><u>DEC 27 1965</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>J Charles Judge</u>                 |  |   |  |

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]

[illegible handwritten text]

[illegible handwritten text]

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>5YRS.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>427 McDOWELL AVENUE</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>d. STREET ADDRESS <b>427 McDOWELL AVENUE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BARBARA</b> Middle <b>KAY</b> Last <b>BUMBAUGH</b>  |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>9</b> Year <b>1965</b>   |  |
| 5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>APRIL 7, 1960</b> 9. AGE (In years last birthday) <b>5</b> yrs. IF UNDER 1 YEAR: Months <b>5</b> Days <b>19</b> Hours <b>65</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-----</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME <b>WILLIAM E. BUMBAUGH</b>  |  | 14. MOTHER'S MAIDEN NAME <b>MARY E. WORTHINGTON</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>-----</b>  |  | 16. SOCIAL SECURITY NO. <b>NONE</b>   |  |
| 17. INFORMANT <b>MRS. MARY BUMBAUGH</b> Address <b>HAGERSTOWN, MD. 427 McDOWELL AVE.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wound Of Left Chest.</b><br>9190<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>-----</b><br>DUE TO (c) <b>-----</b>  |  | INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>Neighbor boy playing with gun.</b>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Home</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>12:30</b> p.m. <b>12-9-</b> 19 <b>65</b>  |  | 20d. INJURY OCCURRED <b>Home</b><br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hagerstown, Washington, Md.</b>   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22. DATE SIGNED <b>12/10/1965</b>   |  |
| ACTUAL SIGNATURE <b>Edward W. Ditto, Jr.</b> M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>EDWARD W. DITTO, JR. M.D. 215 W. WASH. ST. HAGERSTOWN, MD.</b>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 23b. DATE THEREOF <b>DEC. 11, 1965</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>  |  | 23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR <b>Charles M. Koenig</b>   |  | 25a. REC'D BY REGISTRAR <b>DEC 15 1965</b> 25b. REGISTRAR'S SIGNATURE <b>Charles M. Koenig</b>  |  |

00109

WASH DC

WASH DC

147 MONROE AVENUE

WASH DC

APRIL 2, 1960

WASH DC

MARY E. MONTGOMERY

WILLIAM E. MONTGOMERY

MRS. MARY MONTGOMERY

WASH DC

Washed - and the Jack Green.

Washed - and the Jack Green.

Washed - and the Jack Green.

12/10/1960

Washed - and the Jack Green.

WASH DC

WASH DC

Washed - and the Jack Green.

DEC 1 1960

WASH DC



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>   |  |   |  |   |  |   |   |   |  |
|---|--|---|--|---|--|---|---|---|--|
| <b>1. PLACE OF DEATH</b><br><b>a. COUNTY</b> <u>Washington</u> <b>MARYLAND</b>  |  |   |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br><b>a. STATE</b> <u>Maryland <b>b. COUNTY</b> <u>Pro Georges</u> </u> |   |   |   |  |
| <b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |  |   | <b>c. LENGTH OF STAY IN 1b</b>   |   | <b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town)<br><u>Hyattsville, Md. 16X-2</u>   |   |   | <b>d. STREET ADDRESS</b><br><u>2702 Kirkwood Place</u>  |  |
| <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address)<br><u>Western Maryland State Hospital</u>   |  |   |  |   | <b>e. IS RESIDENCE ON A FARM?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>MARY</u> First <u>EVELYN</u> Middle <u>BURTON</u> Last  |  |   |  |   | <b>4. DATE OF DEATH</b> Month <u>DEC</u> Day <u>15</u> Year <u>1965</u>  |   |   |   |  |
| <b>5. SEX</b><br><u>female</u>  |  | <b>6. COLOR OR RACE</b><br><u>white</u>         |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>6-25-1902</u> |   | <b>9. AGE</b> (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>3</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>own home</u>  |   | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Brunswick Md</u>  |   |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U S A</u>   |  |
| <b>13. FATHER'S NAME</b><br><u>John Lethbridge</u>  |  |   |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Katherine Baker</u>  |   |   |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>  |  |   | <b>16. SOCIAL SECURITY NO.</b>   |   | <b>17. INFORMANT</b> Address<br><u>Hospital record Hagerstown, Md.</u>   |   |   |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (a)</b> <u>PNEUMONIA</u><br><u>1991</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>(b)</b> <u>SARCOMATOSIS</u><br><b>(c)</b> <u>SARCOMA OF LEG</u> |  |   |  |   |  |   |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>10 DAYS</u>   |  |
|   |  |   |  |   |  |   |   | <u>UNKNOWN</u>  |  |
|   |  |   |  |   |  |   |   | <u>31 MONTHS</u>  |  |
|   |  |   |  |   |  |   |   | <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b><br><u>DIABETES MELLITUS - ARTERIO SCLEROTIC HEART DISEASE</u> |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)              |   |  |   |   |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>a.m.</u> <u>19</u> p.m.  |  |   | <b>20d. INJURY OCCURRED</b><br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |   | <b>20f. (City or town) (County) (State)</b>                                     |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4-7-</u> <u>1964</u> , <b>to</b> <u>12-15</u> , <u>1965</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12-15-</u> <u>1965</u> , <b>and that death occurred at</b> <u>2:10</u> <u>P</u> , <b>from the causes and on the date stated above.</b>                       |  |   |  |   |  |   |   |   |  |
| <b>22a. SIGNATURE</b><br><u>Antonio U. Pallagrosi</u>   |  |   |  |   | <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>                 |   |   | <b>22b. DATE SIGNED</b><br><u>12-15-65</u>  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>ANTONIO U. PALLAGROSI</u>   |  |   |  |   | <b>22d. ADDRESS</b><br><u>1500 Penn Ave Hagerstown</u>   |   |   |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>Dec 18, 1965</u> |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Ft Lincoln Cemetery</u>   |  |   | <b>23d. LOCATION (City, town or county) (State)</b><br><u>Colmar Manor, Md.</u> |   |  |
| <b>24. FUNERAL DIRECTOR</b><br><u>F. Gasch's Sons Hyattsville, Md.</u>  |  |   |  |   | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 20 1965</u>   |   | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>                       |   |  |

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RECEIVED

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[Faint, mostly illegible text covering the main body of the document, possibly a letter or report. Some words like "RECEIVED" and "10105" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |   |   |  |   |  |   |   |  |  |
|---|--|--|---|---|--|---|--|---|---|--|--|
| CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u><br>c. LENGTH OF STAY IN ID <u>2 wks.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co. Hospital</u>  |  |  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lantz</u><br>d. STREET ADDRESS <u>10X-2</u><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Mary Katherine Calimer</u>  |  |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>4</u> Year <u>1965</u> |   |  | 5. SEX <u>Female</u>  |  |   | 6. COLOR OR RACE <u>White</u>   |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 8. DATE OF BIRTH<br><u>June 28, 1890</u>                            |   |  | 9. AGE (In years last birthday) <u>75</u> yrs.  |  |   | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>  |  |   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u> |   |  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |   | 13. FATHER'S NAME <u>Thaddeus A. Wastler</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Alma S. Royer</u>                                 |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  |  |   | 16. SOCIAL SECURITY NO. <u>213-50-4992</u>  |  |   |  | 17. INFORMANT <u>Mr. H. Lee Calimer</u> Address <u>Lantz, Maryland</u>        |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Failure</u><br>4221<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Obliterans of rt. leg.</u> |  |  |   |   |  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 Days</u><br><u>5 yrs.</u>     |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)              |  |   |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>   |  |  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3-24</u> , 19 <u>58</u> , to <u>12-4</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-3</u> , 19 <u>65</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above.   |  |  |   |   |  |   |  |   |   |  |  |
| 22a. SIGNATURE <u>Charles F. Hess</u>   |  |  |   |   |  | 22b. DATE SIGNED <u>12-4-65</u>   |  | 22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>                           |   | 22d. ADDRESS <u>Smethersboro, Md.</u>                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  |   | 23b. DATE THEREOF <u>12/7/1965</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>  |  |   |   | 23d. LOCATION (City, town or county) (State) <u>Frederick Co., Md.</u> |  |
| 24. FUNERAL DIRECTOR <u>Haltery Shree</u>   |  |  |   | 25a. REC'D BY REGISTRAR <u>DEC 7 1965</u>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                               |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The page should be removed, and in any event, within 72 hours after death.

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |   |  |   |  |   |  |   |  |  |
|--|--|---|--|---|--|---|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL, HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>20 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>AVALON MANOR INC.</b>                      |  |   |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> <b>WASHINGTON</b><br>b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 HAGERSTOWN</b><br>d. STREET ADDRESS <b>115 LINDEN AVENUE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>WILLIAM</b> Middle <b>DEAN</b> Last <b>CANAN</b>  |  |   | <b>4. DATE OF DEATH</b><br>Month <b>DECEMBER</b> Day <b>20</b> Year <b>19 65</b>                                 |   |  |   |  |   |  |  |
| <b>5. SEX</b><br><b>MALE</b>   |  | <b>6. COLOR OR RACE</b><br><b>WHITE</b> |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>MARCH 4, 1887</b>   |  | <b>9. AGE</b> (In years last birthday) <b>78</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. IF UNDER 24 HRS. |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED MECH. ENG.</b>   |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>ENGINEERING CORP.</b>   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>BLAIR CO. PENNSYLVANIA</b>      |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>   |  |  |
| <b>13. FATHER'S NAME</b><br><b>WILLIAM T. CANAN</b>  |  |   |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>MARY C. MYERS</b>  |   |  |   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)   |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>167-05-8592</b>  |  | <b>17. INFORMANT</b><br><b>HAGERSTOWN, MARYLAND</b><br><b>MRS. RUTH CANAN 115 LINDEN AVE.</b> |  |   |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b><br>(c) <b>Hypertensive Vascular Disease</b> |  |   |  |   |  |   |  |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>5 mo.</b><br><b>1 yr.</b><br><b>20 yrs.</b>                |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>  |  |   |  |   |  |   |  |   | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |   | <b>20f. (City or town)</b> (County) (State)  |   |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1954, to Dec. 20, 1965, that (I) (we) last saw the deceased alive on Dec. 20, 1965, and that death occurred at 3 P. M. from the causes and on the date stated above.</b>   |  |   |  |   |  |   |  |   |  |  |
| <b>22a. SIGNATURE</b><br><b>LLOYD A. HOFFMAN M.D.</b>  |  |   |  |   | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>   |   |  | <b>22b. DATE SIGNED</b><br><b>DEC. 21, 1965</b>   |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b>  |  |   |  |   | <b>22d. ADDRESS</b><br><b>214 N. POTOMAC ST. HAGERSTOWN, MD.</b>   |   |  |   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>BURIAL</b>  |  |   | <b>23b. DATE THEREOF</b><br><b>DEC. 22, 1965</b>   |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>REST HAVEN CEMETERY</b>  |   | <b>23d. LOCATION (City, town or county)</b> (State)<br><b>HAGERSTOWN, MARYLAND</b> |   |  |  |
| <b>24. FUNERAL DIRECTOR</b><br><b>Charles M. Boyer</b>   |  |   |  |   | <b>ADDRESS</b><br><b>HAGERSTOWN, MARYLAND</b>  |   | <b>25a. REC'D BY REGISTRAR</b><br><b>DEC 28 1965</b>                               |   | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Charles Judge</b>  |  |



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20 DAYS

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117 LINDEN AVENUE

AVAILA MARCH INC.

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U.S.A.

BLAIR CO. PENNSYLVANIA

PAINTED MACH. INT.

HAGERSTOWN, MARYLAND

MARY C. WYBEG

WILLIAM J. CANAN

107-02-8202 H-8, WITH GAWAN 115 LINDEN AVE.

DEC. 23, 1982

318 W. POTOMAC ST. HAGERSTOWN, MD.

LEO J. HOFFMAN M.D.

HAGERSTOWN, MARYLAND

BEST HAVEN COUNTRY

HAGERSTOWN

DEC 23 1982

HAGERSTOWN, MARYLAND



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

20404

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HAGERSTOWN WASHINGTON MARYLAND</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>Hagerstown</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HAGERSTOWN</u>  |   | c. LENGTH OF STAY IN 1b<br><u>03</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>WASHINGTON COUNTY HOSPITAL</u>  |   | d. STREET ADDRESS<br><u>146 PANGBORN BOULEVARD</u>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>SHIRLEY</u> Middle <u>C.</u> Last <u>CHLEBNIKOW</u>  |   | 4. DATE OF DEATH<br>Month <u>DECEMBER</u> Day <u>14</u> Year <u>19 65</u>   |   |
| 5. SEX<br><u>FEMALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7/9/1924</u>   |
| 9. AGE (In years last birthday)<br><u>41</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                         | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>   | 11. BIRTHPLACE (State or foreign country)<br><u>BOSTON, MASSACHUSETTS</u>                         |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |   |   |
| 13. FATHER'S NAME<br><u>MEYER GREENBERG</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>ROSE KALINA</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)  |   |
| 17. INFORMANT<br><u>ROBERT SCHOEN FUNL HOME</u>  |   | Address<br><u>PATERSON, NEW JERSEY</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of left breast—metastatic</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>to liver and spine and lungs</u><br>DUE TO<br>(c) <u>  </u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>18 months</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pneumonia</u>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>  </u> <u>  </u> <u>19</u>   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>Nov. 13</u> , 19 <u>65</u> , to <u>Dec 14</u> , 19 <u>65</u> , that I last saw the deceased alive on <u>Dec 13</u> , 19 <u>65</u> , and that death occurred at <u>12:01 AM</u> , from the causes and on the date stated above.  |   |   |   |
| ACTUAL SIGNATURE<br><u>John C. Stauffer</u>  |   | ADDRESS (Street, city or town, state)<br><u>WASHINGTON COUNTY HOSPITAL</u>  |   |
| PHYSICIAN'S NAME (Type)<br><u>  </u>   |   | DATE SIGNED<br><u>12/14/65</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>REMOVAL</u>  | 22b. DATE THEREOF<br><u>12/15/65</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>MENORAH CEMETERY</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>PASSAIC, NEW JERSEY</u>                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN ROAD</u>  |   | 24a. REC'D BY REGISTRAR<br><u>DEC 17 1965</u>   | 24b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20405

|   |                           |   |   |   |                                     |
|---|---------------------------|---|---|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Washington  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>Maryland   |   | b. COUNTY<br>Washington   |                                     |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Rural Williamsport #2   |                           | c. LENGTH OF STAY IN 1b<br>20 yrs.  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Williamsport Md. RFD #2 |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Klines Paving Co. Pinesburg   |                           | d. STREET ADDRESS<br>Pinesburg  |   | a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First Roy Middle Gorman Last Colbert   |                           | 4. DATE OF DEATH<br>Month Dec Day 8 Year 19 65  |   |   |                                     |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>March 26 1893 7/7/72 yrs. | 9. AGE (In years last birthday)<br>Months 8 Days 9 Hours Min.   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Watchman   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Paving Co.   |   | 11. BIRTHPLACE (State or foreign country)<br>Sharpsburg Md.   |                                     |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |                           | 13. FATHER'S NAME<br>William Colbert  |   | 14. MOTHER'S MAIDEN NAME<br>Cecelia Gray  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>220-09-9224  |   | 17. INFORMANT<br>Mrs. Flossie Colbert Md. RFD #2  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarct, recent, lateral wall of left ventricle with rupture; hemopericardium; pulmonary congestion and edema.<br>4201 DUE TO<br>(b) Coronary atherosclerosis, severe, with recent thrombotic occlusion of the circumflex<br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br>Instant |                           |   |   |   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                           |   |   |   |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           |   |   |   |                                     |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |   |                                     |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                      |                                     |
| 20f. (City or town)   |                           | (County)  |   | (State)   |                                     |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |   |   |   |                                     |
| ACTUAL SIGNATURE<br>A. E. W. D. T. To   |                           | M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   | 22. DATE SIGNED<br>12/14/65   |                                     |
| EXAMINER'S NAME (Type)<br>A. E. W. D. T. To   |                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | Address (Street, city, town, or county)   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 23b. DATE THEREOF<br>Dec. 12-65   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. View Cemetery   |                                     |
| 23d. LOCATION (City, town or county)<br>Sharpsburg Md.  |                           | (State)   |   |   |                                     |
| 24. FUNERAL DIRECTOR<br>Albert L. Leaf Williamsport Md.   |                           | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DEC 13 1965  |                                     |
|   |                           |   |   | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge  |                                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b>  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>     |  | c. LENGTH OF STAY IN 1b<br><b>65 years</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  | d. STREET ADDRESS<br><b>739 Maryland Ave.</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>LAURA EMMA CROWE</b>   |  | 4. DATE OF DEATH <b>December 5 19 65</b>  |  | 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>  |  | 8. DATE OF BIRTH <b>Mar. 25, 1876</b>  |  |
| 9. AGE (In years last birthday) <b>89</b>   |  | 10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>   |  | 11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Keeper</b>                            |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Apt. House</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Barnes Gap, Penn.</b>              |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  | 13. FATHER'S NAME<br><b>Henry Browning</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Louisa Barnes</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214-09-6497</b>  |  | 17. INFORMANT<br><b>Mrs. Gerald Shank</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b><br>443X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive CV Disease</b><br>8 yrs<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b>   |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  | 21. I certify that (I) (this hospital) attended the deceased from <b>8-15-1965</b> , to <b>12-5-1965</b> , that (I) (we) last saw the deceased alive on <b>12-4-1965</b> , and that death occurred at <b>3:15 A.M.</b> from the causes and on the date stated above. |  | 22a. SIGNATURE<br><b>Robert P. Conrad</b>  |  |
| 22b. DATE SIGNED<br><b>12-6-65</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Robert P. Conrad</b>   |  | 22d. ADDRESS<br><b>1370 Washington St. Hagerstown, Md.</b>  |  | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>12-8-65</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Pauls Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Near Clearspring, Md.</b>                              |  | 24. FUNERAL DIRECTOR<br><b>Scot F. Minnich &amp; Son</b>  |  | 24a. ADDRESS<br><b>Hagerstown, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 10 1965</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |



TO : DIRECTOR, FBI (100-443887)  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum format with various fields and lines of text.]

[Illegible text at the bottom of the page, possibly a signature block or distribution list.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                  |                                   |  |   |  |  |  |  |
|--|--|------------------|-----------------------------------|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                  |                                   |  |   |  |  |  |  |
| 17024  |  |                  |                                   |  | 20407   |  |  |  |  |
| 1. PLACE OF DEATH  |  |                  |                                   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) |  |  |  |  |
| a. COUNTY  |  |                  | Washington                        |  | a. STATE  |  |  | Maryland   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)   |  |                  | Hagerstown                        |  | b. COUNTY   |  |  | Washington   |  |
| c. LENGTH OF STAY IN 1b  |  |                  | 46 years                          |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)      |  |  | Hagerstown   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  |                  |                                   |  | d. STREET ADDRESS   |  |  | e. IS RESIDENCE ON A FARM?   |  |
| Washington County Hospital   |  |                  |                                   |  | 320 W. Wilson Blvd.   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 3. NAME OF DECEASED (Type or print)  |  |                  | First Middle Last                 |  |   | 4. DATE OF DEATH   |  | Month Day Year   |  |
| JAMES FRANKLIN CRUMBACKER  |  |                  |                                   |  |   | December 23  |  | 1965   |  |
| 5. SEX   |  | 6. COLOR OR RACE |                                   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                  |   | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday)  |  |
| Male   |  | White            |                                   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                     |   | Oct. 22, 1918  |  | 47 yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |                  | 10b. KIND OF BUSINESS OR INDUSTRY |  |   | 11. BIRTHPLACE (County & State, or foreign country)                    |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Salesman   |  |                  | Oil Co.                           |  |   | Waynesboro, Pa.  |  |  |  |
| 13. FATHER'S NAME  |  |                  |                                   |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |  |
| William C. Crumbacker  |  |                  |                                   |  | Irma James  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |                  | 16. SOCIAL SECURITY NO.           |  | 17. INFORMANT   |  |  | Address  |  |
| No   |  |                  | 214-09-2896                       |  | Mrs. Agnes G. Crumbacker  |  |  | Hag. Md.   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  |                  |                                   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest due to</i>  |  |                  |                                   |  |   |  |  | <i>Immediate</i>   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>410X</i> <i>① Rheumatic Heart Disease &amp; Mitral Insufficiency</i>   |  |                  |                                   |  |   |  |  | <i>30 yrs</i>  |  |
| (c) <i>② Congestive Heart Failure</i>  |  |                  |                                   |  |   |  |  | <i>2 weeks</i>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                  |                                   |  |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)           |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19   |  |                  |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Dec 15, 1965</i> , to <i>Dec 23, 1965</i> , that (I) (we) last saw the deceased alive on <i>Dec 22, 1965</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above. |  |                  |                                   |  |   |  |  |  |  |
| 22a. SIGNATURE <i>Edward W. Ditto, III, M.D.</i>   |  |                  |                                   |  |   | 22b. DATE SIGNED <i>12-24-65</i>                                       |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <i>Edward W. Ditto, III, M.D.</i>   |  |                  |                                   |  |   | 22d. ADDRESS <i>217 W. Washington St. Hagerstown, Maryland</i>         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                  | 23b. DATE THEREOF                 |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town or county) (State) |  |  |
| Burial   |  |                  | 12-26-65                          |  | Rest Haven Cemetery   |  | Hagerstown, Md.                              |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |                  |                                   |  |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Scott F. Minnich & Son Hagerstown, Md.   |  |                  |                                   |  |   | DEC 29 1965  |  | <i>Charles Judge</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |   |   |   |  |  |  |
|---|--|----------------------------------|---|---|---|---|---|--|--|--|
| 17025   |  |                                  |   |   | 20408   |   |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |   |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Smithburg</u>  |  |                                  | c. LENGTH OF STAY IN 1b<br><u>25 yrs</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Smithburg</u>  |   |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>73 W. Water Street</u>   |  |                                  |   |   | d. STREET ADDRESS<br><u>73 W. Water Street</u>  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Alvey</u> <u>Mason</u> <u>Davis</u>  |  |                                  | First Middle Last   |   | 4. DATE OF DEATH<br><u>Dec.</u> <u>31</u> <u>1965</u>   |   | Month Day Year  |  |  |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>April 14 1910</u> <u>55</u> yrs.                     |   | 9. AGE (In years last birthday)<br>IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>7</u> Days <u>20</u> Hours <u></u> Min. <u></u> |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Labor</u>   |  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Pangborn Corp</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Wash. Co. Md.</u> |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A</u>   |  |  |
| 13. FATHER'S NAME<br><u>Russell Davis</u>   |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Lula Guessford</u>   |   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>  |  |                                  | 16. SOCIAL SECURITY NO.<br><u>213 18 9259</u>   |   | 17. INFORMANT <u>73 W. Water St.</u><br><u>Mrs. Bertha Davis Smithburg Maryland</u>   |   |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Occlusion</u><br><u>4201</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>b) <u></u><br>c) <u>Intermittent</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                                  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 min</u>   |   |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u></u>                                       |   |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. <u>19</u> p.m. <u></u>   |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u></u>   |   | 20f. (City or town) (County) (State)                                      |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 31, 1965</u> to <u>Dec 31, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 31, 1965</u> , and that death occurred at <u>1345</u> M, from the causes and on the date stated above.   |  |                                  |   |   |   |   |   |  |  |  |
| 22a. SIGNATURE<br><u>Geo. A. Williams</u>   |  |                                  |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>  |   | MED. DIRECTOR <input type="checkbox"/>                                    |  | STAFF PHYS. <input type="checkbox"/>               |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Geo. A. Williams</u>   |  |                                  |   |   | 22d. ADDRESS<br><u>Smithburg Md</u>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |                                  | 23b. DATE THEREOF<br><u>Jan. 2-66</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lutheran Cemetery</u>  |   | 23d. LOCATION (City, town or county) (State)<br><u>Smithburg Maryland</u> |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Albert L. Leaf Williamsport Maryland</u>   |  |                                  |   |   | ADDRESS<br><u></u>  |   | 25a. REC'D BY REGISTRAR<br><u>JAN 3 1966</u>                              |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--------------------------------------|--|--|--|--|--|--|--|--|--|--|--|
| 17026   |  |  |  |                                      |  | 20409  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY Washington MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown<br>c. LENGTH OF STAY IN 1b 20 days<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital  |  |  |  |                                      |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Frederick<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Smithsburg 108-2<br>d. STREET ADDRESS Route # 1<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) Oscar Oscar Jennings De Lauter<br>First Middle Last<br>4. DATE OF DEATH DEC 26 19 65<br>Month Day Year  |  |  |  |                                      |  | 5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH March 15, 1900 9. AGE (In years last birthday) 65<br>Month Day Hours Min.  |  |  |  |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker Jamison Co. Hagerstown   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY    |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.            |  |  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.              |  |  |  |
| 13. FATHER'S NAME Charles E. Delauter   |  |  |  |                                      |  | 14. MOTHER'S MAIDEN NAME Linnie Mary Hoover  |  |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no  |  |  |  | 16. SOCIAL SECURITY NO. 220-05-6292  |  |  |  | 17. INFORMANT Mrs. Minnie Delauter, Smithsburg, Md.                              |  |  |  | Address Rt. # 1                                  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 446x UREMIA<br>DUE TO (b) Arteriosclerotic Nephrosclerosis<br>DUE TO (c) Uncontrolled Arteriosclerosis<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Duodenal Ulcer<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 12-7 19 65, to DEC 26, 19 65, that (I) (we) last saw the deceased alive on DEC 26 19 65, and that death occurred at 7:25 PM, from the causes and on the date stated above.  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE E. B. Lardizabal M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22c. PHYSICIAN'S NAME (Type) E. B. Lardizabal   |  |  |  |                                      |  | 22b. DATE SIGNED 12-28-65<br>22d. ADDRESS 2 North Ave, Hagerstown, Md.   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |  |  | 23b. DATE THEREOF Dec. 29, 1965      |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY St. Marks Lutheran, Wolfsville, Fred. Co. Md. |  |  |  | 23d. LOCATION (City, town or county) (State) Md. |  |  |  |
| 24. FUNERAL DIRECTOR Paul F. Bittle   |  |  |  | ADDRESS 2 North Ave, Hagerstown, Md. |  |  |  | 25a. REC'D BY REGISTRAR DEC 29 1965  |  |  |  | 25b. REGISTRAR'S SIGNATURE J. Charles Judge      |  |  |  |

20109

1738

Washington, D.C.

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Re: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

17027

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20410

|   |                               |  |                                     |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |                                     |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>  |                               | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>  |                               | d. STREET ADDRESS <u>250 S. Potomac St.</u>  |                                     |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                     |
| 3. NAME OF DECEASED (Type or print) First <u>Angelo</u> Middle <u>Marino</u> Last <u>DiPolco</u>  |                               | 4. DATE OF DEATH Month <u>December</u> Day <u>17</u> Year <u>19 65</u>   |                                     |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 5, 1881</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs.  |                               | IF UNDER 1 YEAR Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>   |                                     |
| 11. BIRTHPLACE (State or foreign country) <u>Italy</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                     |
| 13. FATHER'S NAME <u>Unknown</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>214-09-2688</u>   |                                     |
| 17. INFORMANT <u>Mrs. Dorothy Weston</u> Address <u>Hagerstown, Md. 250 S. Potomac St.</u>  |                               |  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>9020<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>DUE TO</u><br>(c) <u>DUE TO</u>  |                               | INTERVAL BETWEEN ONSET AND DEATH <u>Sev. days</u>  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis &amp; cervical cord contusion</u>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell from porch injuring head and neck.</u>          |                                     |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>XX</u> e.m. <u>11/9</u> 19 <u>65</u> p.m.  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>  |                               | 20f. (City or town) (County) (State) <u>Hagerstown Wash. Md.</u>   |                                     |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               | 12/17/65   |                                     |
| ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u>   |                               | 22. DATE SIGNED  |                                     |
| EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>   |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Hagerstown, Md.  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>12/20/65</u>  |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>   |                               | 23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>   |                                     |
| 24. FUNERAL DIRECTOR <u>Wm. C. Kent</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>  |                               | 25a. REC'D BY REGISTRAR <u>DEC 20 1965</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>  |                                     |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

81

MEDICAL CERTIFICATION

| <div> <div>17028</div> <div> <div>1</div> <div>M</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>20411</div> </div>   |  |   |  |  |  |  |  |   |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Washington</b> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b><br>c. LENGTH OF STAY in lb<br><b>14 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington Co. Hospital</b>               |  |   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Myersville</b><br>d. STREET ADDRESS<br><b>Route # 2</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><b>NORMAN LUTHER DRAPER</b>  |  |   |  |  |  | <b>4. DATE OF DEATH</b><br>Month <b>December</b> Day <b>24</b> Year <b>1965</b>  |  |   |  |  |  |
| <b>5. SEX</b><br><b>male</b>  |  | <b>6. COLOR OR RACE</b><br><b>white</b> |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>March 4, 1889</b>  |  | <b>9. AGE</b> (In years last birthday) <b>76</b> yrs.<br>IF UNDER 1 YEAR: Months <b>76</b> Days <b>76</b> |  | <b>10. IF UNDER 24 HRS.</b><br>Hours <b>76</b> Min. <b>76</b>                                |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Ret. Farmer</b>  |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Own Gen. Farm</b>   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Frederick Co. Md.</b>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |  |  |
| <b>13. FATHER'S NAME</b><br><b>Somerset Draper</b>  |  |   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Amanda Himes</b>   |  |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>no</b>   |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>215-36-7229</b>   |  | <b>17. INFORMANT</b><br><b>Thomas F. Draper, Myersville, Md. Rt. 2</b>   |  |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic cardiovascular disease</b><br>(e), stating the underlying cause last. (c) <b>Diabetes mellitus</b> |  |   |  |  |  |  |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>2 days</b><br><b>5 years</b><br><b>5 years</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)  |  |   |  |  |  |  |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br><b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)   |  |  |  |
| <b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>8-7</b> , 1958, to <b>12-24</b> , 1965, that (I) (we) last saw the deceased alive on <b>12-23</b> , 1965, and that death occurred at <b>640am</b> , from the causes and on the date stated above.   |  |   |  |  |  |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><b>Charles F. Hess</b>   |  |   |  |  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>   |  | <b>22b. DATE SIGNED</b>   |  |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>Charles F. Hess, M.D.</b>   |  |   |  |  |  | <b>22d. ADDRESS</b><br><b>Smithsburg, Maryland</b>   |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>   |  |   |  | <b>23b. DATE THEREOF</b><br><b>Dec. 26, 1965</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Mt. Bethel M.E.</b>  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><b>Nr. Smithsburg, Md.</b>                         |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Paul F. Bittle</b>  |  |   |  |  |  | <b>ADDRESS</b><br><b>Myersville, Md.</b>   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>DEC 28 1965</b>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Charles Judge</b>                                    |  |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17029

20412

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Washington   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>Maryland                                    |  | b. COUNTY<br>Washington  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hagerstown,  |  | c. LENGTH OF STAY IN 1b<br>Unknown   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hagerstown   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Washington County Hospital   |  |  |  | d. STREET ADDRESS<br>Hager Hotel<br>S. Potomac Street  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Robert   |  | First<br>J.  |  | Middle<br>Dunn   |  |
| 5. SEX<br>Male   |  | 6. COLOR OR RACE<br>White  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>Unknown  |  | 9. AGE (In years last birthday)<br>89 yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Unknown   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Unknown   |  | 11. BIRTHPLACE (State or foreign country)<br>Unknown   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>Unknown  |  | 13. FATHER'S NAME<br>Unknown   |  | 14. MOTHER'S MAIDEN NAME<br>Unknown  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>Unknown   |  | 16. SOCIAL SECURITY NO.<br>232-26-6839   |  | 17. INFORMANT<br>Hagerstown City Police Report   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) 9166 Pulmonary Edema - Hypostatic Pneumonia<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>DUE TO due 2°-3° Burns 80% Body Surface<br>DUE TO<br>(c)   |  | INTERVAL BETWEEN ONSET AND DEATH<br>36 hr<br>48 hr   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>under sedation - set fire to chair while smoking |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour M.m. 12-17 65<br>11:50 m.   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work at work                             |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>Hager Hotel  |  |
| 20f. (City or town)<br>Hagerstown  |  | 20g. (County)<br>Washington  |  | 20h. (State)<br>Md.  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Schwartz W. Ditto III  |  | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | 22. DATE SIGNED<br>12/22/65  |  |
| EXAMINER'S NAME (Type)<br>Edward W. Ditto III, M.D.  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | Address (Street, city, town, or county)<br>Hag., Md.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>12/22/65  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rose Hill  |  |
| 23d. LOCATION (City, town or county)<br>Hagerstown, Maryland   |  | 23e. REC'D BY REGISTRAR<br>DEC 28 1965   |  | 23f. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |
| 24. FUNERAL DIRECTOR<br>Scott F. Minnick   |  | ADDRESS<br>West Wilson Blvd Hag.   |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

17030

20413

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MAUGANSVILLE</b><br>c. LENGTH OF STAY IN 1b <b>LIFE</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MAUGANSVILLE AENNONITE HOME</b>                          |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>MD</b><br>b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X MAUGANSVILLE MD</b><br>d. STREET ADDRESS <b>MAUGANSVILLE, MD.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>E</b> Last <b>ESHLEMAN</b>  |  |  |  | 4. DATE OF DEATH Month <b>Dec</b> Day <b>15</b> Year <b>1965</b>  |  |  |  |
| 5. SEX <b>F</b>   |  | 6. COLOR OR RACE <b>W</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>12/12/1887</b>                                   |  |
| 9. AGE (In years last birthday) <b>78</b> yrs.  |  | 10. UNDER 1 YEAR Months <b>7</b> Days <b>15</b>  |  | 11. UNDER 24 HRS. Hours <b>15</b> Min.  |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Wm</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>REID MD</b>   |  |
| 13. FATHER'S NAME <b>DAVID H. ESHLEMAN</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>MAMIE REIFF</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |  |  | 16. SOCIAL SECURITY NO. <b>265-40-7908</b>  |  | 17. INFORMANT <b>Wm Hoge Martin</b> Address <b>Hagerstown RD#4</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>443X Hypertension</b><br>DUE TO (b) <b>Coronary Artery Disease</b><br>DUE TO (c) <b>Heart Failure</b><br>Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                 |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11-10-64</b> , 19 <b>64</b> , to <b>12-15</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12-14-65</b> , 19 <b>65</b> , and that death occurred at <b>6A</b> M, from the causes and on the date stated above.                                     |  |  |  |   |  |  |  |
| 22a. SIGNATURE <b>A. E. W. Little</b>   |  |  |  | 22b. DATE SIGNED  |  | 22c. PHYSICIAN'S NAME (Type) <b>A. E. W. Little</b>                  |  |
| 22d. ADDRESS <b>Hagerstown Md</b>   |  |  |  | 22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22f. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF <b>Dec 17 1965</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Reef Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State) <b>WASHINGTON CO MD</b> |  |
| 24. FUNERAL DIRECTOR <b>A E Quinn</b> ADDRESS <b>Greencastle Pa</b>   |  |  |  | 25a. REC'D BY REGISTRAR <b>DEC 17 1965</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>                    |  |

05251

DATE: \_\_\_\_\_

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

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DAVID M. EISENBERG

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11/11/11

1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

20414

17031

|  |                                  |   |   |  |   |   |  |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Martinsburg</u> 251.3                                     |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Martin Manor Rest Home</u>  |                                  |   |   | d. STREET ADDRESS<br><u>513 Edgemont Terrace</u>   |   |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Beuenna</u> Middle <u>Sophia</u> Last <u>Fleming</u>   |                                  |   |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>26</u> Year <u>19 65</u>  |   |   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 4, 1903</u> |  | 9. AGE (In years lost birthday)<br><u>62 yrs.</u> | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>     | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Nurse</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Berkeley County, W. Va.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>William Canter Shade</u>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Vertie V. Parsons</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>  </u>  |   | 17. INFORMANT<br><u>Robert B. Fleming</u> Address <u>Takoma Park, Maryland</u>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of cervix with</u><br><u>171X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized Metastases</u> DUE TO<br>(c) <u>  </u>   |                                  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 yrs</u>                                      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |                                  |   |   |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Nov 12</u> , 19 <u>60</u> , to <u>Dec 26</u> , 19 <u>65</u> , that I last saw the deceased alive on <u>Dec 26</u> , 19 <u>65</u> , and that death occurred at <u>5:58</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>212 W. Washington St. Hagerstown, MD</u> DATE SIGNED <u>12/26/65</u> |                                  |   |   |  |   |   |  |
| ACTUAL SIGNATURE <u>Edward W. Ditto III, M.D.</u>  |                                  |   |   |  |   |   |  |
| PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>   |                                  |   |   |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>12-29-1965</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rosedale Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Martinsburg, Berkeley, W. Va.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>N. R. Brown</u><br>Brown Funeral Home   |                                  |   |   | ADDRESS<br><u>Martinsburg, W. Va.</u>  |   | 24a. REC'D BY REGISTRAR<br><u>DEC 29 1965</u>   |  |
|  |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |   |  |

CERTIFICATE OF DEATH

1911

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| NAME OF DECEASED<br>[Faint text, possibly "John Doe"]            |  | SEX<br>[Faint text, possibly "Male"]  |  | AGE<br>[Faint text, possibly "45"]                             |  | DATE OF BIRTH<br>[Faint text, possibly "Jan 1, 1866"]                     |  |
| PLACE OF BIRTH<br>[Faint text, possibly "Maryland"]              |  | OCCUPATION<br>[Faint text, possibly "Farmer"]                                 |  | CAUSE OF DEATH<br>[Faint text, possibly "Heart Disease"]       |  | DATE OF DEATH<br>[Faint text, possibly "Dec 1, 1911"]                     |  |
| PLACE OF DEATH<br>[Faint text, possibly "Home"]                  |  | TIME OF DEATH<br>[Faint text, possibly "10:00 AM"]                            |  | SIGNATURE OF PHYSICIAN<br>[Faint text, possibly "J. H. Smith"] |  | SIGNATURE OF REGISTRAR<br>[Faint text, possibly "A. B. Jones"]            |  |
| SIGNATURE OF NEXT OF KIN<br>[Faint text, possibly "Mrs. J. Doe"] |  | ADDRESS OF NEXT OF KIN<br>[Faint text, possibly "123 Main St, Baltimore, Md"] |  | SIGNATURE OF WITNESS<br>[Faint text, possibly "C. D. White"]   |  | ADDRESS OF WITNESS<br>[Faint text, possibly "456 Elm St, Baltimore, Md"]  |  |
| SIGNATURE OF DECEASED<br>[Faint text, possibly "John Doe"]       |  | ADDRESS OF DECEASED<br>[Faint text, possibly "789 Oak St, Baltimore, Md"]     |  | SIGNATURE OF DECEASED<br>[Faint text, possibly "John Doe"]     |  | ADDRESS OF DECEASED<br>[Faint text, possibly "789 Oak St, Baltimore, Md"] |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND<br>CERTIFICATE OF DEATH  |  |                                   |  |   |  |   |  |   |  |  |  |
|--|--|-----------------------------------|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u><br>c. LENGTH OF STAY IN 1b <u>2 1/2 YRS</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor, Inc.</u>   |  |                                   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle, Pa. 7543</u><br>d. STREET ADDRESS <u>101 E. Baltimore St.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>THOMAS HENRY GILLAND</u>  |  |                                   |  |   |  | 4. DATE OF DEATH <u>DEC. 8 1965</u>   |  |   |  |  |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>     |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>2/8/1884</u>  |  | 9. AGE (In years last birthday) <u>81</u> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor general practice</u>   |  |                                   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Greencastle, Pa.</u>   |  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |  |  |
| 13. FATHER'S NAME <u>DR. John Conrad Gilland</u>   |  |                                   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Martha Snyder</u>   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>   |  |                                   |  |   |  | 16. SOCIAL SECURITY NO. <u>W.W.I. 204-30-6685</u>   |  |   |  |  |  |
| 17. INFORMANT <u>Mrs. Daisy Gilland</u>  |  |                                   |  |   |  | Address <u>Greencastle, Pa.</u>   |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br>4208 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized.</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia - Acute</u> |  |                                   |  |   |  |   |  |   |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH   |  |                                   |  |   |  |   |  |   |  |  |  |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |                                   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)            |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21. I certify that (I) (the hospital) attended the deceased from <u>8/19</u> , 19 <u>63</u> , to <u>12/8</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-8</u> 19 <u>65</u> , and that death occurred at <u>3:06 PM</u> , from the causes and on the date stated above.  |  |                                   |  |   |  |   |  |   |  |  |  |
| 22a. SIGNATURE <u>Charles A. Hoffner</u>   |  |                                   |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   | 22b. DATE SIGNED <u>12/9/65</u>            |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffner</u>   |  |                                   |  |   |  | 22d. ADDRESS <u>244 N. Pot-st. Hagerstown, Md.</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF <u>12/11/65</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State) <u>Greencastle, Pa.</u>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR <u>A.E. Minnich</u>   |  |                                   |  |   |  | 25a. RECD BY REGISTRAR <u>DEC 13 1965</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
 20M 5-63

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                        |   |  |   |  |   |                    |  |  |
|--|--|--|------------------------|---|--|---|--|---|--------------------|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |                        |   |  |   |  |   |                    |  |  |
| CERTIFICATE OF DEATH   |  |  |                        |   |  |   |  |   |                    |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b>  |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown Maryland</b> |                        | c. LENGTH OF STAY IN 1b<br><b>55yrs</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>            |  | b. COUNTY<br><b>Washington</b>  |                    |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>37 W. Bethel Street</b>   |  |  |                        |   |  | d. STREET ADDRESS<br><b>37 W. Bethel Street</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                    |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Rosie</b>   |  |  | First<br><b>Harmon</b> |   |  | Middle<br><b>Goens</b>  |  |   | Last<br><b>Dec</b> |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Colored</b>   |                        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept 1 1897</b>  |  | 9. AGE (In years last birthday)<br><b>68</b>  |                    | 10. IF UNDER 1 YEAR<br>Months Days<br><b>16</b>                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |                        | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Winchester, Va.</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |                    |  |  |
| 13. FATHER'S NAME<br><b>Harry B. Harmon</b>  |  |  |                        |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Minnie Wells</b>   |  |   |                    |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>219-01-8601</b>  |                        | 17. INFORMANT<br><b>Spencer Goens 37 W. Bethel Street</b>   |  |   |  |   |                    | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>4201</b> DUE TO <b>Arteriosclerosis of the Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b><br>(a), stating the underlying cause last. DUE TO <b>Arteriosclerosis of the Heart</b><br>(c) <b>Arteriosclerosis of the Heart</b> |  |  |                        |   |  |   |  |   |                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b><br><b>years</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |                        |   |  |   |  |   |                    |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |                    |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  |  |                        | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br><b>Dec</b>   |                    | (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> to <b>Dec 1965</b> , that (I) (we) last saw the deceased alive on <b>12/16</b> , and that death occurred at <b>11:30</b> AM, from the causes and on the date stated above.  |  |  |                        |   |  |   |  |   |                    |  |  |
| 22a. SIGNATURE<br><b>Philip J. Hirshman</b>  |  |  |                        |   |  | M.D.  |  | 22b. DATE SIGNED<br><b>12/17/65</b>   |                    | 22c. PHYSICIAN'S NAME (Type)<br><b>Philip J. Hirshman, M.D.</b>                    |  |
| 22d. ADDRESS<br><b>159 W. Wash. St., Hagerstown, Md.</b>   |  |  |                        |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |   |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>12-20-1965</b>   |                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  |   |  | 23d. LOCATION (City, town or county) (State)<br><b>Hagerstown Md.</b>                             |                    |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John R. Watson Jr. Hagerstown Md.</b>   |  |  |                        |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 21 1965</b>   |                    | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |  |

STATE OF TEXAS

1933

County of \_\_\_\_\_

Know all men by these presents, \_\_\_\_\_

of the County of \_\_\_\_\_ State of Texas,

do hereby certify that \_\_\_\_\_

is the owner of the \_\_\_\_\_

and that the same is subject to a mortgage

in favor of \_\_\_\_\_

and that the same is being sold by \_\_\_\_\_

at \_\_\_\_\_

for the purpose of \_\_\_\_\_

and that the proceeds of the sale

shall be applied to the payment of the

and the balance of the proceeds

shall be paid to the owner of the

and that the same is being sold by \_\_\_\_\_

at \_\_\_\_\_

for the purpose of \_\_\_\_\_

and that the proceeds of the sale

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17034  
20417  
CERTIFICATE OF DEATH

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>50 YRS.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b><br>d. STREET ADDRESS <b>1 6 SUTER AVE.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>LEE</b> Last <b>GUESSFORD SR.</b>   |   | 4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>15</b> Year <b>1965</b>   |   |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>4/7/1901</b>                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MACHINIST</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>  | 11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b> |
| 13. FATHER'S NAME <b>SAMUEL L. GUESSFORD</b>  |   | 14. MOTHER'S MAIDEN NAME <b>MINERVA SHAFFER</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |   | 16. SOCIAL SECURITY NO. <b>213-12-7189A</b>   |   |
| 17. INFORMANT <b>MRS. KATHERINE GUESSFORD</b>   |   | Address <b>HAGERSTOWN MD.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonitis</b><br>DUE TO (b) <b>CARCINOMA of Lung</b><br>DUE TO (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR Disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION C/W IN PART I(a)<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR Disease</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wk</b><br><b>6 mo?</b>     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 9, 1965</b> to <b>Dec. 15, 1965</b> , that (I) (we) last saw the deceased alive on <b>Dec. 15, 1965</b> , and that death occurred at <b>6:08 PM</b> , from the causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE <b>Richard V. Hauger</b>   |   | 22b. DATE SIGNED <b>Dec. 16</b>   | 22c. PHYSICIAN'S NAME (Type) <b>RICHARD V. HAUGER</b>               |
| 22d. ADDRESS <b>HAGERSTOWN, MD</b>  |   | 22e. REC'D BY REGISTRAR <b>DEC 23 1965</b>  |   |
| 22f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |   | 22g. ADDRESS <b>HAGERSTOWN, MD</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |   | 23b. DATE THEREOF <b>12/17/65</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>            |
| 23d. LOCATION (City, town or county) <b>Hagerstown</b>  |   | (State) <b>MD.</b>  |   |
| 24. FUNERAL DIRECTOR <b>W. J. Norment</b>   |   | 24a. ADDRESS <b>Hagerstown, Md.</b>   |   |

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Washington

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

20418

|  |  |   |  |   |  |  |  |  |  |  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b>  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>     |  | c. LENGTH OF STAY IN lb<br><b>2 weeks</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>Washington</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b> |  | d. STREET ADDRESS<br><b>804 Woodland Way</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>PAUL WOODROW HARBAUGH</b>  |  | First   |  | Middle  |  | Last   |  | 4. DATE OF DEATH<br>Month<br><b>Dec.</b>   |  | Day<br><b>15</b>   |  | Year<br><b>1965</b>   |  |   |  |  |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 18, 1913</b>  |  | 9. AGE (In years last birthday)<br><b>52</b> yrs.  |  | IF UNDER 1 YEAR<br>Months<br><b>0</b>  |  | Days<br><b>0</b>  |  | Hours<br><b>0</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Harbaugh Enterprise Co.</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Harbaugh Enterprise Co.</b>                                       |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Highfield Wash. Co.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Raymond T. Harbaugh</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Nettie Brown</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>                    |  | 16. SOCIAL SECURITY NO.<br><b>Richard Babylon</b>   |  | 17. INFORMANT<br><b>804 Woodland Way</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO (b) <b>Pulmonary Contusion</b><br>DUE TO (c) <b>Chronic Corruptive Heart Failure</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Atherosclerotic Cardio-Vascular Disease</b> |  |   |  |   |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>?</b><br><b>2 months</b>                  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)              |  |   |  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  | 21. I certify that (I) (this hospital) attended the deceased from <b>14 Nov.</b> , 19 <b>65</b> , to <b>15 Dec.</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>15 Dec.</b> , 19 <b>65</b> , and that death occurred at <b>8:20</b> AM, from the causes and on the date stated above. |  | 22a. SIGNATURE<br><b>W. N. Fender</b>  |  | 22b. DATE SIGNED<br><b>17 Dec. 65</b>   |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>W. N. Fender</b>  |  | 22d. ADDRESS<br><b>218 N. Potomac St. Hagerstown, Md.</b>   |  | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                   |  | 22f. ADDRESS<br><b>218 N. Potomac St. Hagerstown, Md.</b>  |  | 22g. DATE<br><b>DEC 22 1965</b>  |  | 22h. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  | 22i. REGISTRAR'S NAME<br><b>Charles Judge</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>13/17/65</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Hagerstown, Md.</b>   |  | 23e. ADDRESS<br><b>40 E. Antietam</b>  |  | 23f. DATE<br><b>DEC 22 1965</b>  |  | 23g. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  | 23h. REGISTRAR'S NAME<br><b>Charles Judge</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11203

11203





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FOR STATE HEALTH DEPT.

17036

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20419

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>rural Hagerstown</b><br>c. LENGTH OF STAY IN 1b<br><b>18 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>R. F. D. 1</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Wash.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>rural Hagerstown</b><br>d. STREET ADDRESS<br><b>R. F. D. 1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>DONALD</b><br>Middle<br><b>LEE</b><br>Last<br><b>HARTLE</b>   |   | 4. DATE OF DEATH<br>Month<br><b>December</b><br>Day<br><b>24</b><br>Year<br><b>19 65</b>  |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Feb. 29, 1947</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>painter</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>contractor</b>  | 9. AGE (In years last birthday)<br><b>18</b> yrs.<br>IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Jugtown, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>John H. Hartle</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Bessie R. Sager</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.<br><b>219-44-3632</b>   |  |
| 17. INFORMANT<br><b>John H. Hartle, RFD Hag., Md.</b>  |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e)<br><b>gun shot wound of Head</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)             |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>turned</b>  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Self inflicted gunshot wound in Head</b>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>12<sup>th</sup> p.m. 12/24 1965</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>   | 20f. (City or town) (County) (State)<br><b>Jugtown Wash Md</b>   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE<br><b>Edward W. Ditto III, M.D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><b>217 W. Washington ST. Hagerstown, Md.</b>  |  |
| EXAMINER'S NAME (Type)<br><b>Edward W. Ditto, III, M.D.</b>  |   | 22. DATE SIGNED<br><b>12-26-65</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   | 23b. DATE THEREOF<br><b>12-27-65</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   | 23d. LOCATION (City, town or county) (State)<br><b>Hagerstown, Md.</b>   |
| 24. FUNERAL DIRECTOR<br><b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 30 1965</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

1133

Washington

Franklin D. Roosevelt

March 1, 1933

Dear Sir:

Very truly yours,

Franklin D. Roosevelt

Secretary of War

John D. Martin

March 1, 1933

Very truly yours,



Respectfully,  
John D. Martin

John D. Martin

John D. Martin

John D. Martin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
1SM 9/55

17037

CERTIFICATE OF DEATH

Reg. Dist. No. 20420

|   |                        |  |  |
|---|------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Washington MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Washington                          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown   |                        | c. LENGTH OF STAY IN 1b 1 month  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown  |                        | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital  |  |
| d. STREET ADDRESS 2210 Ontario Drive  |                        | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last Roger Christopher Heavner   |                        | 4. DATE OF DEATH Month Day Year Dec. 25 19 65  |  |
| 5. SEX Male   | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 24 1947                            |
| 9. AGE (In years lost birthday) 18 yrs.   |                        | IF UNDER 1 YEAR Months Days Hours Min. 10  | IF UNDER 24 HRS. 10                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter   |                        | 10b. KIND OF BUSINESS OR INDUSTRY Hardwood Floors  | 11. BIRTHPLACE (State or foreign country) Cumberland Md. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A  |                        | 13. FATHER'S NAME Carl Heavner   |  |
| 14. MOTHER'S MAIDEN NAME Alma Redinger  |                        | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No  |  |
| 16. SOCIAL SECURITY NO. 219 46 3321   |                        | 17. INFORMANT Address 2210 Ontario Drive Mr. Carl Heavner Hagerstown Maryland  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1952 Malignant thymoma - generalized carcinomatosis 6-8 Mo.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)  |                        | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                        | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19  |                        | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                        | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from Nov 24, 1965, to Dec 25, 1965, that I last saw the deceased alive on Dec 25, 1965, and that death occurred at 8:15 P.M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE Edward W. Ditto III M.D. 212 W. Washington St. 12/26/65<br>PHYSICIAN'S NAME (Type) Edward W. Ditto III MD Hagerstown, Maryland |                        |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                        | 22b. DATE THEREOF Dec. 28-65   |  |
| 22c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery  |                        | 22d. LOCATION (City, town, or county) (State) Hagerstown Maryland  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert L. Leaf Williamsport Maryland   |                        | 24a. RECEIVED BY REGISTRAR DATE DEC 29 1965  |  |
| 24b. REGISTRAR'S SIGNATURE Charles Judge  |                        |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|
| 17038 CERTIFICATE OF DEATH 20421   |  |  |  |  |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>1 YR.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>740 1/2 MARYLAND AVE.</b>  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b><br>d. STREET ADDRESS <b>740 1/2 MARYLAND AVENUE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>AGNES CORDELIA HELEINE</b><br>First Middle Last<br>4. DATE OF DEATH <b>DECEMBER 19 19 65</b><br>Month Day Year  |  |  |  |  | 5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <b>JAN. 16, 1893</b> 9. AGE (In years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SALESLADY</b><br>10b. KIND OF BUSINESS OR INDUSTRY <b>HAT STORE</b><br>11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  |  | 13. FATHER'S NAME <b>ELLSWORTH OSBORNE</b><br>14. MOTHER'S MAIDEN NAME <b>NAOMI POMPELL</b>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)<br>16. SOCIAL SECURITY NO. <b>217-28-7224</b><br>17. INFORMANT <b>OSBORNE C. HELEINE</b><br>Address <b>HAGERSTOWN, MARYLAND 751 SUMMIT AVE.</b>  |  |  |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 8-12 hr. <b>uncertain</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease, arteriosclerotic, 10 yr. with hypertensive cardiovascular disease</b><br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b><br>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |  |  |  | 21. I certify that (I) (this hospital) attended the deceased from <b>Aug.</b> , 19 <b>64</b> , to <b>Dec. 19</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec. 14</b> , 19 <b>65</b> , and that death occurred at <b>approximately 6 a.m.</b> M, from the causes and on the date stated above.<br>22a. SIGNATURE <b>B.B. KNEISLEY M.D.</b> <b>approximately 6 a.m.</b> 22b. DATE SIGNED <b>12/21/1965</b><br>22c. PHYSICIAN'S NAME (Type) <b>B.B. KNEISLEY M.D.</b> 22d. ADDRESS <b>148 W. WASHINGTON ST. HAGERSTOWN, MD.</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b><br>23b. DATE THEREOF <b>DEC. 22, 1965</b><br>23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b><br>23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>   |  |  |  |  | 24. FUNERAL DIRECTOR <b>Charles Judge</b> ADDRESS <b>HAGERSTOWN, MARYLAND</b><br>25a. REC'D BY REGISTRAR <b>DEC 27 1965</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |  |  |  |

100-100000

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

2001 WASHINGTON AVE.

2001 WASHINGTON AVE.

100-100000

WASHINGTON

WASHINGTON

WASHINGTON

JAN. 16, 1905

1

WASHINGTON

WASHINGTON

WASHINGTON CO., WASHINGTON D.C.

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON CO., WASHINGTON AVE.

WASHINGTON

WASHINGTON

8-12 ft. deep

Government acquisition

Government acquisition, approximately 10 ft. deep, with hypodermic needle-like structure

Dec. 13, 1905

Dec. 14, 1905

approximately 6 ft.

12/13/1905

U.S. WASHINGTON ST. WASHINGTON, D.C.

U.S. WASHINGTON D.C.

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VR A15ME  
5M 1/62

BP

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |  |   |   |  |
|---|--|---|--|---|--|--|--|--|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |  |  |  |   |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sandy Hook</b> |  | c. LENGTH OF STAY IN life<br><b>Life</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>e. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>Washington</b>               |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sandy Hook</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Highway -- U.S. 340</b>  |  |   |  |   |  | d. STREET ADDRESS<br><b>U.S. 340</b>   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>SCOTT</b>  |  | First<br><b>HOLDER</b>  |  | Middle<br><b>HIMES</b>  |  | Last   |  | 4. DATE OF DEATH<br><b>Dec. 24,</b>          |   | Day<br><b>19 65</b>   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Oct. 25, 1912</b>   |  | 9. AGE (In years last birthday)<br><b>53</b> |   | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>General</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Sandy Hook, Md.</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |  |
| 13. FATHER'S NAME<br><b>John Quincy Himes</b>   |  |   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Holder</b>   |  |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>WW II 220-09-9373</b>   |  | 17. INFORMANT<br><b>Mrs. Marguirite Himes</b><br><b>Harpers Ferry, West Va.</b>                                      |  |  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Crushing Injury to Skull</b><br><b>8124</b><br>DUE TO (b) <b>Complete Decapitation of Body at</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Palais</b><br>DUE TO (c) <b>Multiple Fractures Entire Body</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Walking on Highway - Struck by Speeding Auto</b> |  |   |  |   |  |  |  |  |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.<br><input checked="" type="checkbox"/>  |  |   |  | 2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Walking on Highway - Struck by Speeding Auto</b>          |  |  |  |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>9:25 a.m. Dec 24 1965</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)<br><b>Rt 340 Bridge Sandy Hook Wash. Md</b>         |  | 20f. (City or town)<br><b>Sandy Hook</b>     |   | 20g. (County)<br><b>Washington</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |   |  |   |  |  |  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Edward W. Dittus III</b>   |  |   |  |   |  | ASSISTANT MEDICAL EXAMINER<br><input type="checkbox"/>   |  |  | DATE SIGNED<br><b>12-24-65</b>  |   |  |
| EXAMINER'S NAME (Type)<br><b>Edward W. Dittus III, M.D.</b>   |  |   |  |   |  | ASSISTANT MEDICAL EXAMINER<br><input checked="" type="checkbox"/>  |  |  | Address (Street, city, town, or county)<br><b>217 W. Washington St. Harpers Ferry, West Va.</b>   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>12/27/65</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Old Brethren Cemetery</b>  |  | 22d. LOCATION (City, town, or country)<br><b>Brownsville</b>   |  | 22e. (State)<br><b>Maryland</b>              |   | 24a. REC'D BY REGISTRAR<br><b>DEC 28 1965</b>   |  |
| 23. FUNERAL DIRECTOR<br><b>J. Donald Eackles</b>  |  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |  |   |   |  |

5013

5013

①

Washington  
May 1900  
Dear Sir  
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the matter of the proposed extension of the line of the Washington & Annapolis Electric Railway Company from the city of Washington to the city of Annapolis. The Board of Directors of the Company has considered the matter and has decided to grant the extension of the line to the city of Annapolis. The Board has also decided to grant the extension of the line to the city of Annapolis. The Board has also decided to grant the extension of the line to the city of Annapolis.

Very truly yours,  
John W. Smith  
President  
Washington & Annapolis Electric Railway Company  
11-2-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17040

CERTIFICATE OF DEATH

20423

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reid, Md.</u><br>c. LENGTH OF STAY IN 1b <u>—</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md.</u><br>b. COUNTY <u>Wash.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reid, Md.</u><br>d. STREET ADDRESS <u>Reid, Md.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Susie</u> First <u>H.</u> Middle <u>Horst</u> Last<br>4. DATE OF DEATH <u>12/13</u> Month <u>12</u> Day <u>13</u> Year <u>1965</u>   |  |  |  | 5. SEX <u>F.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/23/1881</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Wash. Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |  |  |  | 13. FATHER'S NAME <u>Henry H. Baer</u> 14. MOTHER'S MAIDEN NAME <u>Susie Horst</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Alvin H. Horst - Hagerstown, Md.</u> Address <u>RD 6</u>  |  |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Rectum</u><br>154X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  | 21. I certify that (I) (this hospital) attended the deceased from <u>9-28</u> , 19 <u>48</u> , to <u>12-13</u> , 19 <u>65</u> , that (I) <del>was</del> last saw the deceased alive on <u>12-13</u> , 19 <u>65</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <u>Dalton M. Welty</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  | 22b. DATE SIGNED  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Dalton M. Welty M.D.</u>  |  |  |  | 22d. ADDRESS <u>998 Potomac Ave. Hagerstown, Md.</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>   |  | 23b. DATE THEREOF <u>12/17/65</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Millers Ch. Cem.</u>  |  | 23d. LOCATION (City, town or county) (State) <u>near Hagerstown, Md.</u>                               |  |
| 24. FUNERAL DIRECTOR <u>A.C. Minnich - Greencastle, Pa.</u> ADDRESS   |  |  |  | 25a. REC'D BY REGISTRAR <u>DEC 16 1965</u> DATE   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |  |  |   |   |  |  |
|---|--|---|--|--|--|---|---|--|--|
| CERTIFICATE OF DEATH  |  |   |  |  |  |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>46 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>319 N. Cannon Ave.</b>                                     |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>d. STREET ADDRESS <b>319 N. Cannon Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |  |
| 3. NAME OF DECEASED (Type or print) <b>CLARENCE SAMUEL HOTTLE</b>   |  |   |  |  | 4. DATE OF DEATH <b>December 24 1965</b>   |   |   |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>                     |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 8. DATE OF BIRTH <b>July 22, 1916</b>                                       |   | 9. AGE (In years last birthday) <b>49 yrs.</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b> |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Funkstown, Md.</b>  |  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |  |
| 13. FATHER'S NAME <b>A. C. Hottle</b>   |  |   |  |  | 14. MOTHER'S MAIDEN NAME <b>Zelda Robinson</b>   |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>217-09-9530</b>        |  | 17. INFORMANT <b>Mrs. Mildred L. Hottle</b> Address <b>Hag. Md.</b>  |  |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b><br>DUE TO (c) <b>Coronary Artery Sclerosis</b> |  |   |  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>min.</b><br><b>hrs.</b><br><b>"</b>                        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> , 19 <b>65</b> , to <b>12/24</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12/18</b> , 19 <b>65</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.  |  |   |  |  |  |   |   |  |  |
| 22a. SIGNATURE <b>D. J. Boyer</b>   |  |   |  | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>   |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED <b>12/27/65</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>D. J. Boyer, M.D.</b>   |  |   |  | 22d. ADDRESS <b>136 N. Potomac Street, Hagerstown, Md.</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>12-28-65</b>                 |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>  |  |   | 23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b> |  |  |
| 24. FUNERAL DIRECTOR <b>Scott F. Minnich &amp; Son</b>  |  |   |  | ADDRESS <b>Hagerstown, Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>DEC 30 1965</b>                                  |   | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>   |  |

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b>   |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b> |  | c. LENGTH OF STAY IN 1b<br><b>40 years</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington County Hospital</b>  |  |   |  |   |  | d. STREET ADDRESS<br><b>57 S. Potomac St.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>RALPH</b>  |  | First <b>SPESSARD</b>   |  | Middle <b>HOUSER</b>  |  | Last  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>16</b> Year <b>19 65</b>                                |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 29, 1893</b>   |  | 9. AGE (in years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR Months Oays IF UNDER 24 HRS. Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Desk Clerk</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hotel</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Cavetown, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>George Houser</b>  |  |   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ella Spessard</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>  |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>J. Robert Houser</b> Address <b>Hagerstown, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b><br><b>4200</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) <b>Lung tumor, possibly malignant</b> |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>acute</b><br><b>3 years possible</b><br><b>unknown</b>            |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>None</b>  |  |   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 8</b> , 1965, to <b>Dec. 16</b> , 1965, that (I) (we) last saw the deceased alive on <b>Dec. 16</b> , 1965, and that death occurred at <b>11:15 p.m.</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><i>J. Walter Layman</i>  |  |   |  | 22b. DATE SIGNED<br><b>Dec. 18., 1965</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>J. Walter Layman, M.D.</b>   |  |  |  |
| 22d. ADDRESS<br><b>100 Professional Arts Bldg. Hagerstown, Maryland</b>  |  |   |  | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>                            |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>12-20-65</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Smithsburg Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Smithsburg, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 22 1965</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Scott F. Minnich &amp; Son</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i>   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |   |  |   |  |  |   |  |  |
|---|--|--|--|---|--|---|--|--|---|--|--|
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>4 YRS.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MARTIN MANOR NURSING HOME</b>  |  |  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>d. STREET ADDRESS <b>304 v WAKEFIELD RD.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>HOVERMILL</b>  |  |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>23</b> Year <b>65</b> |   |  | 5. SEX <b>MALE</b>  |  |  | 6. COLOR OR RACE <b>WHITE</b>                           |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 8. DATE OF BIRTH <b>12/26/1879</b>                                     |   |  | 9. AGE (in years last birthday) <b>85</b> yrs.  |  |  | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MACHINIST</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>   |  |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>               |  |  |
| 13. FATHER'S NAME <b>SHAFAER HOVERMILL</b>  |  |  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>JOSEPHINE CREEK</b>   |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  |  |  | 16. SOCIAL SECURITY NO. <b>196-07-4671</b>  |  | 17. INFORMANT <b>MRS. LOUISE SPANGLER</b>   |  |  | Address <b>HAGERSTOWN MD.</b>                           |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b><br>4500 DUE TO (b) <b>Generalized Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |   |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b><br><b>yr.</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                               |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>61</b> to <b>12/23</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12/21</b> , 19 <b>65</b> , and that death occurred at <b>5:45</b> AM, from the causes and on the date stated above.   |  |  |  |   |  |   |  |  |   |  |  |
| 22a. SIGNATURE <b>D. J. Boyer</b>   |  |  |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  | 22b. DATE SIGNED <b>12/24/65</b>                        |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>D. J. Boyer, M.D.</b>   |  |  |  |   |  | 22d. ADDRESS <b>136 N. Potomac St., Hagerstown, Md.</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |  | 23b. DATE THEREOF <b>12/27/65</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b> |   |  | 23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b> |   |  |  |
| 24. FUNERAL DIRECTOR <b>W. J. Normant, Hagerstown, Md.</b>  |  |  |  |   |  | 25a. REC'D BY REGISTRAR <b>DEC 30 1965</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>                 |   |  |  |

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304 WATERGATE RD.

MARTIN LUTHER KING JR.

DECEMBER 23, 1958

WILLIAM P. BRYANT

JOHN

12/23/58

THIS DATE

MARYLAND

RAIL ROAD

REAR END

JOSEPHINE CARR

SHARON ROBERTSON

WASHINGTON

1958-07-10-11 MRS. LOUISE SPANGLER

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*Central Transfer*

*Washington, D.C.*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR AIS (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |   |   |  |  |  |  |  |
|---|--|----------------------------------|---|---|---|---|--|--|--|--|--|
| 17044 CERTIFICATE OF DEATH 20427  |  |                                  |   |   |   |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> MARYLAND   |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> |   |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>   |  |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 HAGERSTOWN</b>                                      |   |  |  |  |  |  |
| c. LENGTH OF STAY in 1b<br><b>6 DAYS</b>  |  |                                  |   |   | d. STREET ADDRESS<br><b>804 WASHINGTON AVE.</b>   |   |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>WASHINGTON COUNTY HOSPITAL</b>   |  |                                  |   |   |   |   |  |  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                  |   |   |   |   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HOWARD</b> Middle <b>WILLIAM</b> Last <b>HUFFMAN</b>  |  |                                  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>23</b> Year <b>19 65</b> |   |   |   |  |  |  |  |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>AUG. 21, 1895</b>  |  | 9. AGE (In years last birthday) <b>70</b> yrs.                                   |  | IF UNDER 1 YEAR: Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED PIPE FITTER</b>   |  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>  |   |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>PAGE CO., VIRGINIA</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>HERBERT HUFFMAN</b>   |  |                                  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>CARRIE HOCKMAN</b>   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  |                                  |   | 16. SOCIAL SECURITY NO.<br><b>214-09-8913</b>   |   | 17. INFORMANT<br><b>HAGERSTOWN, MD.<br/>MRS. ISABEL HUFFMAN 804 WASH. AVE.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>4500</b> DUE TO (b) <b>Generalized Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                                  |   |   |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>10 yrs</b>                           |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |   |   |   |   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> , 19 <b>64</b> , to <b>12/23</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12/23</b> , 19 <b>65</b> , and that death occurred at <b>2:30</b> P.M. from the causes and on the date stated above.  |  |                                  |   |   |   |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Dr. Martin</b>   |  |                                  |   |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>12/24/1965</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DONALD E. MARTIN M.D.</b>  |  |                                  |   |   |   | 22d. ADDRESS<br><b>418 N. POTOMAC ST. HAGERSTOWN, MD.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |                                  | 23b. DATE THEREOF<br><b>DEC. 27, 1965</b>                                 |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ROSE HILL CEMETERY</b>   |   |  | 23d. LOCATION (City, town or county) (State)<br><b>HAGERSTOWN MARYLAND</b>       |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Roy B. Dawson</b>  |  |                                  |   |   |   | ADDRESS<br><b>ROUZER FUNERAL HOME<br/>HAGERSTOWN, MARYLAND</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 29 1965</b>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

3043

1011

WASHINGTON

MARYLAND

WASHINGTON

WASHINGTON

6 DAYS

WASHINGTON

304 WASHINGTON AVE.

WASHINGTON COUNTY HOSPITAL

62

13

DECEMBER

HUTCHINSON

WILLIAM

HOWARD

WHITE

MALE

NOV. 21, 1902

U.S.A.

PAGE 00, VIRGINIA

RAILROAD

RETIRED FIRE FIGHTER

CARLIS HOOKMAN

HENRY HOOKMAN

WASHINGTON, D.C.

NOV. 21, 1902

NO

*Thomas*

*Thomas*

12/24/1902

DR. H. POTOMAC ST. WASHINGTON, D.C.

DR. H. POTOMAC ST. WASHINGTON, D.C.

WASHINGTON, MARYLAND

WASHINGTON, MARYLAND

WASHINGTON, MARYLAND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

17045

20428

|   |                               |   |                                      |   |   |   |                  |
|---|-------------------------------|---|--------------------------------------|---|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                               |   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |   |                  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>  |                               |   |                                      | c. LENGTH OF STAY IN 1b <b>1 Week</b>   |   |   |                  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Martin Manor Nursing Home</b>   |                               |   |                                      | e. STREET ADDRESS <b>1300 Virginia Ave</b>  |   |   |                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Susan</b> Middle <b>Mae</b> Last <b>Itnyer</b>  |                               |   |                                      | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>29</b> Year <b>1965</b>  |   |   |                  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>May 19, 1887</b> | 9. AGE (In years last birthday) <b>78</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>   |                                      | 11. BIRTHPLACE (County & State, or foreign country) <b>Maugansville, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>   |                  |
| 13. FATHER'S NAME <b>John W. Jones</b>  |                               |   |                                      | 14. MOTHER'S MAIDEN NAME <b>Susan M. Hause</b>  |   |   |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>217-10-2687</b>  |                                      | 17. INFORMANT <b>Mrs. Audrey Martin</b> Address <b>1300 Va. Ave Hagerstown, Maryland</b>  |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b><br>DUE TO (c) <b>General atherosclerosis</b> |                               |   |                                      |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>2 wks.</b><br><b>?</b>   |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |   |                                      |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |   |   |   |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>                          |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> , 19 <b>65</b> , to <b>Dec 30</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec. 29</b> , 19 <b>65</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.   |                               |   |                                      |   |   |   |                  |
| 22a. SIGNATURE <b>[Signature]</b>   |                               |   |                                      | 22b. DATE SIGNED <b>12/30/65</b>  |   |   |                  |
| 22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>  |                               |   |                                      | 22d. ADDRESS <b>159 W. Washington St., Hagerstown, Md.</b>  |   |   |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>Jan. 1, 1966</b>   |                                      | 23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>   |   | 23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>                 |                  |
| 24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc.</b>   |                               |   |                                      | 25a. REC'D BY REGISTRAR <b>JAN 3 1966</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                       |                  |
| Hagerstown, Md.   |                               |   |                                      |   |   |   |                  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |   |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |  |
| 20429  |  |   |  |   |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>   |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>  |  |   |  |   | c. LENGTH OF STAY IN 1b<br><b>3 DAYS</b>  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON COUNTY HOSPITAL</b>  |  |   |  |   | e. STREET ADDRESS<br><b>6 S. HIGH STREET</b>  |  |  |  |  |
| f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |   |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ANNIE</b> Middle <b>MAY</b> Last <b>KERFOOT</b>  |  |   |  |   | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>25</b> Year <b>19 65</b>   |  |  |  |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>APRIL 1, 1887</b>   |  | 9. AGE (In years last birthday) <b>78</b> yrs.<br>IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b><br>IF UNDER 24 HRS: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MAINTAINED HOME</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>FAYETTE CO., PENNA</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>THOMAS F. KERFOOT</b>  |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE ARTHUR</b>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>-----</b>   |  |   |  |   | 16. SOCIAL SECURITY NO.<br><b>219-20-4998</b>   |  | 17. INFORMANT<br><b>FUNKSTOWN, MARYLAND</b><br><b>MRS. OLA BALL 6 S. HIGH STREET</b> |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary artery thrombosis</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |   |  |   |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b><br>p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12-23</b> , 19 <b>65</b> , to <b>12-25</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12-25</b> , 19 <b>65</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above.  |  |   |  |   |   |  |  |  |  |
| 22a. SIGNATURE<br><b>George Jennings</b>   |  |   |  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |  | 22b. DATE SIGNED<br><b>12/27/1965</b>  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE JENNINGS M.D.</b>  |  |   |  |   | 22d. ADDRESS<br><b>318 N. POTOMAC ST. HAGERSTOWN, MD.</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>DEC. 28/1965</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ROSE HILL CEMETERY</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>HAGERSTOWN, MARYLAND</b>      |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Charles Rouzer</b>  |  |   |  |   | ADDRESS<br><b>ROUZER FUNERAL HOME</b><br><b>HAGERSTOWN, MARYLAND</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 3 1966</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17047

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20430

|  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. CDUNTY<br><b>WASHINGTON</b><br>b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HANCOCK MD.</b><br>c. LENGTH OF STAY IN 1b<br><b>LIFE</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>HOME</b>   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. CDUNTY<br><b>WASHINGTON</b><br>c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HANCOCK MD.</b><br>d. STREET ADDRESS<br><b>1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>KAREN SUE KNABLE</b>  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>12 3 19 65</b> |  |  |  |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. CILDR DR RACE<br><b>W</b>   |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |
| 8. DATE OF BIRTH<br><b>1.8.1963</b>  |  | 9. AGE (In years last birthday)<br><b>2</b> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>2</b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>INFANT</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>WASHINGTON COUNTY MD</b>   |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>LEWIS KNABLE</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>FRANCES WELLER</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |   | 17. INFORMANT<br><b>FRANCES KNABLE HANCOCK MD.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fourth Degree Burns - entire</b><br><b>9160</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Body (Almost total Incineration)</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b> |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.<br><input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>trapped in First Floor of Home During Fire.</b> |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>10 00 a.m. 12/3 1965</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>                                  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |  |  |  |
| 20f. (City or town)<br><b>Hancock Wash</b>   |  | 20g. (County)<br><b>MD</b>   |   | 20h. (State)<br><b>MD</b>  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                                       |  |  |   |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Edward W. Ditto III</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22. DATE SIGNED<br><b>12-3-65</b>  |  |  |  |
| EXAMINER'S NAME (Type)<br><b>Edward W. Ditto III</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>12.5.65</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ORCHARD RIDGE</b>   |  |  |  |
| 23d. LOCATION (City, town or county)<br><b>RURAL HANCOCK WASHINGTON</b>  |  | 23e. (State)<br><b>MD</b>  |   | 23f. (Country)<br><b>MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Howard J. Stone Hancock md</b>  |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR<br><b>DEC 7 1965</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |  |   |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

17048

20431

|  |                                    |  |                                      |
|--|------------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Wash.</u> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |                                      |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |                                    | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Cabin John 15 X-2</u>   |                                      |
| c. LENGTH OF STAY IN 1b<br><u>1 year</u>   |                                    | d. STREET ADDRESS<br><u>8110 Seven Lock Road</u>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Western Maryland State Hospital</u>   |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <u>TROY</u> Middle <u>KNIGHT</u> Last <u>KNIGHT</u>   |                                    | 4. DATE OF DEATH<br>Month <u>DEC</u> Day <u>6</u> Year <u>1965</u>   |                                      |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>Negroid</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3-24-1905</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Cement finisher</u>  |                                    | 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                      |
| 10b. KIND OF BUSINESS OR INDUSTRY  |                                    | 11. BIRTHPLACE (County & State, or foreign country)<br><u>North Carolina</u>   |                                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                    | 13. FATHER'S NAME<br><u>Unknown</u>  |                                      |
| 14. MOTHER'S MAIDEN NAME<br><u>Amanda ?</u>  |                                    | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>                                     |                                      |
| 16. SOCIAL SECURITY NO.<br><u>579 09 8128</u>  |                                    | 17. INFORMANT<br><u>30 R. T. Ave., N.W. Rosa M. Wood- Washington, D. C.</u>  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lobular Pneumonia</u><br>223X DUE TO (b) <u>Frontal Lobe Meningioma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>not known</u> |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                    | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |                                    | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-19-</u> , 19 <u>62</u> , to <u>12-6</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-5-</u> 19 <u>65</u> , and that death occurred at <u>3:40</u> M, from the causes and on the date stated above.                                  |                                    |  |                                      |
| 22a. SIGNATURE<br><u>Arturo Riego</u>  |                                    | 22b. DATE SIGNED<br><u>12-6-65</u>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><u>ARTURO RIEGO</u>  |                                    | 22d. ADDRESS<br>M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>     |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                    | 23b. DATE THEREOF<br><u>12-11-65</u>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lincoln Mem. Cem.</u>   |                                    | 23d. LOCATION (City, town or county) (State)<br><u>Suitland, Md.</u>   |                                      |
| 24. FUNERAL DIRECTOR<br><u>Frazier's Funeral Home, Wash, D. C.</u>   |                                    | 25a. REC'D BY REGISTRAR<br><u>DEC 10 1965</u>  |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>  |                                    |  |                                      |

18181

ESTIMATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |                                  |   |                                    |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wsshington</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md</b> b. COUNTY <b>Prince Georges</b>                 |                                    |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bladensburg 16X-2</b>  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Western Md State Hospital</b>  |                                  | d. STREET ADDRESS<br><b>5425 Taussig Road</b>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br><b>Joseph A. Kurtinitis</b>  |                                  | 4. DATE OF DEATH<br><b>12-11-1965</b>   |                                    |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/15/99</b> |
| 9. AGE (In years last birthday)<br><b>66 yrs.</b>   |                                  | 10. IF FUNER 1 YEAR <input type="checkbox"/> IF FUNER 24 HRS. <input type="checkbox"/>  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Foreman</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Novelty co</b>  |                                    |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |                                    |
| 13. FATHER'S NAME<br><b>George Kurtinitis</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Stepanovich</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>178 03 3281</b>   |                                    |
| 17. INFORMANT<br><b>Hospital records Hagerstown Md.</b>   |                                  | Address   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lobular Pneumonia</b><br>4341<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Chronic Congestive heart failure</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Arteriosclerosis, General</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>yes</b>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7-21-1965</b> to <b>12-11-1965</b> , that (I) (we) last saw the deceased alive on <b>12-10-1965</b> , and that death occurred at <b>12 P</b> M, from the causes and on the date stated above.  |                                  |   |                                    |
| 22a. SIGNATURE<br><b>Arthur D. Riego</b>  |                                  | 22b. DATE SIGNED<br><b>12-11-65</b>   |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ARTHUR D. RIEGO</b>  |                                  | 22d. ADDRESS<br><b>1500 Penna. Ave., Hagerstown, Md.</b>  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>Ded 14, 1965</b>  |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>  |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Wheaton Md.</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons Hyattsville, Md.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 16 1965</b>   |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  |   |                                    |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                       |   |  |   |   |  |  |  |
|--|--|---------------------------------------|---|--|---|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                       |   |  |   |   |  |  |  |
| CERTIFICATE OF DEATH   |  |                                       |   |  |   |   |  |  |  |
| 20433  |  |                                       |   |  |   |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SMITHSBURG</b><br>c. LENGTH OF STAY IN 1b <b>85 YEARS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>EDGEMONT RFD SMITHSBURG</b>   |  |                                       |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SMITHSBURG</b><br>d. STREET ADDRESS <b>EDGEMONT RFD SMITHSBURG</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>First ELISE Middle LOOSE Last LANE</b>  |  |                                       |   |  | 4. DATE OF DEATH <b>Month DECEMBER Day 30, Year 1965</b>  |   |  |  |  |
| 5. SEX <b>FEMALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>         |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>NOV. 5, 1880</b>  |  | 9. AGE (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>   |  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b> |  |   | 11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>SAMUEL B. LOOSE</b>   |  |                                       |   |  | 14. MOTHER'S MAIDEN NAME <b>ROSE NEGLEY</b>   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |                                       | 16. SOCIAL SECURITY NO. <b>NONE</b>               |  | 17. INFORMANT Address <b>SAMUEL L. LANE - RFD # 3-SMITHSBURG, MARYLAND</b>  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201 Acute Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Coronary Thrombosis</b><br>(c) <b>Arterio sclerotic heart disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized Arteriosclerosis</b><br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that (I) (this hospital) attended the deceased from <b>March, 1965</b> , to <b>Dec 30, 1965</b> , that (I) (we) last saw the deceased alive on <b>Dec 20, 1965</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.<br>22a. SIGNATURE <b>Walter H. Wishard</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22b. DATE SIGNED <b>12-31-65</b><br>22c. PHYSICIAN'S NAME (Type) <b>WALTER H. WISHARD</b><br>22d. ADDRESS <b>152 W. Main St., Waynesboro, Penna.</b> |  |                                       |   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>   |  | 23b. DATE THEREOF <b>JAN. 3, 1966</b> |   | 23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>   |   | 23d. LOCATION (City, town or county) (State) <b>WASHINGTON 23, D.C.</b>             |  |  |  |
| 24. FUNERAL DIRECTOR <b>Charles M. Pounce</b> ADDRESS <b>HAGERSTOWN, MARYLAND</b>  |  |                                       |   | 25a. REC'D BY REGISTRAR <b>JAN 4 1966</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles M. Pounce</b>                                 |  |  |  |



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WASHINGTON, D.C.

WILLIAM B. WARD

WASHINGTON, D.C.

11. 2, 1980 CEDAR HILL ORATORY

WASHINGTON

WASHINGTON, MARYLAND



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17051

20434

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>WASHINGTON<br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br>MARYLAND<br>b. COUNTY<br>ALLEGANY                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>HAGERSTOWN   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>RFD OLDTOWN   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>WASHINGTON COUNTY HOSPITAL   |  | d. STREET ADDRESS<br>ROUTE 1,   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>VICTOR A. LIVENGOOD   |  | 4. DATE OF DEATH<br>Month Day Year<br>DEC. 19, 19 65  |   |
| 5. SEX<br>MALE   | 6. COLOR OR RACE<br>WHITE  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>JUNE 30, 1939   |
| 9. AGE (In years last birthday)<br>26 yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>IRON WORKER   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>CONSTRUCTION   |   |
| 11. BIRTHPLACE (State or foreign country)<br>MARYLAND  |  | 12. CITIZEN OF WHAT COUNTRY<br>USA  |   |
| 13. FATHER'S NAME<br>VERNON A. LIVENGOOD   |  | 14. MOTHER'S MAIDEN NAME<br>KATHRYN WILSON  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>NO  |  | 16. SOCIAL SECURITY NO.<br>218 38 0288  |   |
| 17. INFORMANT<br>KATHLEEN LIVENGOOD RT. 1, OLDTOWN, MD.  |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 9023<br>DUE TO pulmonary Edema + hypostatic pneumonia - due Fracture Body of 5th cervical vertebrae - complete transection of cord<br>(b) 5th cervical vertebrae - complete transection of cord<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br>2-3 days<br>5 days |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.<br>3 p.m. 12-16-65   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>Fall off scaffolding - Struck Head + Neck                   |   |
| 20c. TIME OF INJURY<br>Hour 3 p.m.   | 20d. INJURY OCCURRED<br>While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |   |   |
| ACTUAL SIGNATURE<br>Edward W. Ditto III  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) EDWARD W. DITTO, III  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 22b. DATE THEREOF<br>DEC. 23, 1965  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br>DAVIS MEMORIAL PARK  |  | 22d. LOCATION (City, town, or county) (State)<br>CUMBERLAND, MD.  |   |
| 23. FUNERAL DIRECTOR<br>BYRON KIGHT  |  | 24a. REC'D BY REGISTRAR<br>DATE DEC 28 1965   |   |
| 24b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  | DATE  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

17052

20589

|   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u><br>c. LENGTH OF STAY IN 1b <u>2 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co. Hospital</u> |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Frederick</u></span><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville 10 X 2</u><br>d. STREET ADDRESS <u>Route # 1 Smithsburg</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>EDGAR BYRD MARTIN</u><br>First Middle Last  |  |  |  | <b>4. DATE OF DEATH</b> <u>December 6, 1966</u><br>Month Day Year  |  |  |  |  |  |
| <b>5. SEX</b><br><u>male</u>  |  | <b>6. COLOR OR RACE</b><br><u>white</u>  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><u>Feb. 2, 1897</u>   |  | <b>9. AGE</b> (In years last birthday) <u>68</u> yrs.<br>IF UNDER 1 YEAR: Months Days Hours Min.         |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Machinst</u>   |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Frick Co.</u>   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Frederick Co. Md.</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>   |  |
| <b>13. FATHER'S NAME</b><br><u>Scott T. Martin</u>  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Mary E. Hoover</u>   |  |  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u><br>(If yes give war or dates of service)   |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>213-18-8164</u>   |  | <b>17. INFORMANT</b> Address <u>Rt. # 1 Md. Mrs. Marjorie M. Martin, Smithsburg, Md.</u> |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial failure</u><br>DUE TO (b) <u>coronary artery disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>pneumonia</u><br>DUE TO                   |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>3 month</u><br><u>3 days</u>                      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)  |  |  |  |
| <b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>1-3, 1955</u> to <u>1-6, 1966</u> , that (I) (we) last saw the deceased alive on <u>1-5, 1966</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.  |  |  |  |  |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Charles F. Hess</u>   |  |  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br>M.D.   |  | <b>22b. DATE SIGNED</b><br><u>1-7-66</u>   |  |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Charles F. Hess, M.D.</u>   |  |  |  | <b>22d. ADDRESS</b><br><u>Smithsburg, Maryland 21783</u>   |  |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial Jan. 9, 1966</u>  |  | <b>23b. DATE THEREOF</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>United Brethern</u>  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Wolfsville, Fred. Co. Md.</u>  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Paul F. Bittle</u>  |  |  |  | <b>25a. REC'D BY REGISTRAR</b><br><u>JAN 11 1966</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>                                |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND<br>CERTIFICATE OF DEATH  |  |                           |   |  |  |  |   |   |  |  |  |
|--|--|---------------------------|---|--|--|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HANCOCK</b><br>c. LENGTH OF STAY IN MD <b>LIFE</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOME</b>   |  |                           |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL 1</b><br>d. STREET ADDRESS <b>HANCOCK MD.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>PAMELA</b> Middle <b>SUE</b> Last <b>McCUSKER</b>  |  |                           |   |  | 4. DATE OF DEATH<br>Month <b>12.</b> Day <b>8</b> Year <b>1965</b>   |  |   |   |  |  |  |
| 5. SEX <b>F</b>  |  | 6. COLOR OR RACE <b>W</b> |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>4.26.65</b>  |   | 9. AGE (In years last birthday) <b>8</b> IF UNDER 1 YEAR: Months <b>8</b> Days <b>13</b> Hours <b>19</b> Min. <b>65</b> |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>  |  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>INFANT</b>   |  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>MORGAN COUNTY W.VA.</b> |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>   |  |  |  |
| 13. FATHER'S NAME <b>KENNETH L McCUSKER</b>  |  |                           |   |  | 14. MOTHER'S MAIDEN NAME <b>BERTHA E HEMICK</b>  |  |   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |                           | 16. SOCIAL SECURITY NO. <b>NONE</b>   |  | 17. INFORMANT <b>KENNETH L McCUSKER RURAL 1 HANCOCK MD.</b> Address  |  |   |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>0821 Acute Meningitis</b><br>DUE TO (b) <b>Virus Infection</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                           |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>3da</b>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)              |  |  |  |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                    |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec 10, 1965</b> , to <b>Dec 13, 1965</b> , that (I) (we) last saw the deceased alive on <b>Dec 13, 1965</b> , and that death occurred at <b>4:30</b> M, from the causes and on the date stated above.  |  |                           |   |  |  |  |   |   |  |  |  |
| 22a. SIGNATURE <b>L.M. Shaffer</b>   |  |                           |   |  | 22b. DATE SIGNED <b>DEC 20 1965</b>  |  |   | 22c. ADDRESS <b>HANCOCK MD.</b>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>L.M. SHAFFER</b>   |  |                           | 22d. ADDRESS <b>HANCOCK MD.</b>   |  |  |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  |                           | 23b. DATE THEREOF <b>12.15.65</b>   |  | 23c. NAME OF CEMETERY OR <b>MT. OLIVET</b>   |  | 23d. LOCATION (City, town or county) <b>RURAL HANCOCK WASHINGTON MD</b> |   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Howard J. Shore Hancock &amp; Md</b>   |  |                           |   |  | 25a. REC'D BY REGISTRAR <b>DEC 20 1965</b>   |  |   |   |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b> |  |

5-85

1943



CERTIFICATE OF DEATH

1943

MASSACHUSETTS

WASHINGTON

DEATH

LIFE

DEATH

HANDBOOK NO.

100

JOE

JOE

PAVELA

1943

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

*Handwritten signature and text, possibly 'L. M. Switzer'.*

1943

*Handwritten signature.*

L. M. SWITZER

HANDBOOK NO.

MASSACHUSETTS

DEATH

DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                   |   |   |  |                                     |  |  |  |
|--|--|-----------------------------------|---|---|--|-------------------------------------|--|--|--|
| 17054 CERTIFICATE OF DEATH 20436   |  |                                   |   |   |  |                                     |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>LIFE</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>  |  |                                   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>d. STREET ADDRESS <b>836 S. POTOMAC ST.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>JOSEPH EDWARD MILLER</b>   |  |                                   | 4. DATE OF DEATH<br><b>DECEMBER 13 19 65</b>  |   |  |                                     |  |  |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>     |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/3/1889</b> |  | 9. AGE (In years last birthday) <b>76</b><br>IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MACHINIST</b>   |  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>  |   | 11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>  |                                     |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>WILLIAM G. MILLER</b>   |  |                                   |   |   | 14. MOTHER'S MAIDEN NAME <b>IDA SEMLER</b>   |                                     |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |                                   | 16. SOCIAL SECURITY NO. <b>NONE</b>   |   | 17. INFORMANT Address <b>MRS. JEAN WARD TIMONIUM MD.</b>   |                                     |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b><br><b>4221</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |                                   |   |   |  |                                     |  | INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |                                     |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |  |                                   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)                               |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12-12-65</b> , 19 <b>65</b> , to <b>12-13-</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12-13-</b> , 19 <b>65</b> , and that death occurred at <b>6:15</b> P.M., from the causes and on the date stated above.  |  |                                   |   |   |  |                                     |  |  |  |
| 22a. SIGNATURE <b>E. W. Ditto</b>  |  |                                   |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |                                     | 22b. DATE SIGNED <b>12-14-65</b>                                   |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>   |  |                                   |   |   | 22d. ADDRESS <b>215 W. Washington St., Hagerstown, Md.</b>   |                                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE THEREOF <b>12/15/65</b> |   | 23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>  |  |                                     | 23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b> |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>W. J. Normant, Hagerstown, Md.</b>   |  |                                   |   |   | 25a. REC'D BY REGISTRAR DATE <b>DEC 20 1965</b>  |                                     | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>                 |  |  |

20130

DEPARTMENT OF STATE

1000

WASHINGTON

MARYLAND

WASHINGTON

MARYLAND

LAKE

HARRINGTON

836 E. POTOMAC ST.

WASHINGTON COUNTY HOSPITAL

RECEIVED

MILWAUKEE

EDWARD

JOSEPH

76

10/3/1903

X

WHITE

MARYLAND

RAIL ROAD

LESTER HARRINGTON

IDA BRANSON

WILLIAM G. MILLER

THOMAS H. MOORE

MRS. JEAN WARD

HOME

WOOD

1903

WASHINGTON COUNTY HOSPITAL

10-11-03

10-11-03

10

10-11-03

10-11-03

10-11-03

10

HARRINGTON

ROSE HILL

10/15/03

HARRINGTON

10-11-03

10

10-11-03

10-11-03

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17055

20437

|   |                                  |   |   |  |   |   |  |
|---|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>WASHINGTON</b>   |                                  | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |   | b. COUNTY<br><b>WASHINGTON</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>   |                                  | c. LENGTH OF STAY IN ID<br><b>24 HRS.</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>                |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>WASHINGTON COUNTY HOSPITAL</b>   |                                  |   |   | d. STREET ADDRESS<br><b>1023 POTOMAC AVENUE</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>WILLIAM F. MILLS, SR.</b>  |                                  | First Middle Last   |   | 4. DATE OF DEATH<br><b>DECEMBER 6, 1965</b>  |   | Month Day Year  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 5, 1922</b> |  | 9. AGE (In years last birthday)<br><b>43 yrs.</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MACHINIST FOREMAN</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>MACK TRUCKS</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>NEW JERSEY</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>FREDERICK MILLS</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>ELSIE JORGENSEN</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>W.W. II 072-14-4042</b>   |   | 17. INFORMANT<br><b>PLAINFIELD, N. JERSEY</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bullet Wound Of Head (entrance right temple)</b><br>976 X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hours</b>   |   |  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Self inflicted.</b>                                      |   |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>8 p.m.</b> <b>12-5-</b> <b>1965</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>                                |   | 20f. (City or town) (County) (State)<br><b>Hagerstown, Washington, Md.</b>                        |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |  |   |   |  |
| ACTUAL SIGNATURE<br><i>[Signature]</i>  |                                  | M.O.  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22. DATE SIGNED<br><b>12/6/1965</b>   |  |
| EXAMINER'S NAME (Type)<br><b>EDWARD W. DITTO, JR. M.D.</b>  |                                  | 215 W. WASHINGTON ST.   |   | HAGERSTOWN, MD.  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   |                                  | 23b. DATE THEREOF<br><b>DEC. 6, 1965</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CLOVER LEAF PARK CEM.</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>WOODBIDGE, NEW JERSEY</b>                      |  |
| 24. FUNERAL DIRECTOR<br><i>[Signature]</i>  |                                  | ADDRESS<br><b>HAGERSTOWN, MARYLAND</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DEC 8 1965</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                      |   |   |  |   |   |  |  |
|---|--|--------------------------------------|---|---|--|---|---|--|--|
| CERTIFICATE OF DEATH  |  |                                      |   |   |  |   |   |  |  |
| 20438   |  |                                      |   |   |  |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>55 YRS.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>716 SUNSET AVE.</b>   |  |                                      |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b><br>d. STREET ADDRESS <b>716 SUNSET AVE.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GARL</b> Middle <b>WILLIAM</b> Last <b>MITCHELL</b>   |  |                                      |   |   | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>24</b> Year <b>1965</b>   |   |   |  |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>        |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8/19/1882</b>                                |   | 9. AGE (In years last birthday) <b>82</b> yrs.<br>IF UNDER 1 YEAR: Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED AUTO SERVICE STATION OWNER</b>   |  |                                      |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b> |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>WILLIAM HENRY MITCHELL</b>  |  |                                      |   |   | 14. MOTHER'S MAIDEN NAME<br><b>WILMOTH BURKE</b>   |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  |                                      | 16. SOCIAL SECURITY NO. <b>217-32-5372</b>  |   | 17. INFORMANT<br><b>MRS. CHARLOTTE MITCHELL</b>  |   |   | Address <b>HAGERSTOWN MD.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>443x</b> DUE TO <b>Hypertensive Crisis Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Dissecting Aneurysm</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                      |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1955</b><br><b>June 20, 1965</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                      |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)  |  |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec 6</b> , 1963, to <b>Dec 24</b> , 1965, that (I) (we) last saw the deceased alive on <b>Dec 23</b> , 1965, and that death occurred at <b>8:57</b> AM, from the causes and on the date stated above.   |  |                                      |   |   |  |   |   |  |  |
| 22a. SIGNATURE<br><b>Sidney Novershteyn</b>   |  |                                      |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>M.D. <b>FUNKS</b>   |   |   | 22b. DATE SIGNED<br><b>12-26-65</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>SIDNEY NOVERSTEIN</b>  |  |                                      |   |   | 22d. ADDRESS<br><b>FUNKS M.D.</b>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>12/27/65</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR LAWN MEM. GARDENS</b>  |  |   | 23d. LOCATION (City, town or county) (State)<br><b>HAGERSTOWN MD.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>W. J. Normant Hagerstown Md.</b>   |  |                                      |   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 30 1965</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                 |  |  |

STATE OF NEW YORK  
COUNTY OF NEW YORK  
IN SENATE  
JANUARY 1, 1903

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 1, 1903

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1903

THE SENATE  
JANUARY 1, 1903

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1903

THE SENATE  
JANUARY 1, 1903

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1903

THE SENATE  
JANUARY 1, 1903

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ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1903

THE SENATE  
JANUARY 1, 1903

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1903



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND<br>CERTIFICATE OF DEATH  |  |                                   |   |   |  |   |   |   |  |   |  |
|--|--|-----------------------------------|---|---|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>24 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>  |  |                                   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>d. STREET ADDRESS <b>729 Maryland Ave.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>WILLIAM FREDERICK MONG, SR.</b><br>First Middle Last  |  |                                   |   |   | 4. DATE OF DEATH <b>December 21, 1965</b><br>Month Day Year  |   |   |   |  |   |  |
| 5. SEX <b>male</b>   |  | 6. COLOR OR RACE <b>white</b>     |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Jan. 16, 1911</b>   |   | 9. AGE (in years last birthday) <b>54 yrs.</b><br>IF UNDER 1 YEAR: Months Days Hours Min. |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unit chairman</b>   |  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <b>aircraft mftg.</b>   |   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Waynesboro, Penna.</b> |   | 12. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 13. FATHER'S NAME <b>George J. Mong</b>  |  |                                   |   |   | 14. MOTHER'S MAIDEN NAME <b>Susan Myers</b>  |   |   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b><br>(If yes give war or dates of service) <b>WW II</b>   |  |                                   | 16. SOCIAL SECURITY NO. <b>214-09-3491</b>  |   | 17. INFORMANT <b>Mrs. Emma Mong, Hagerstown, Md.</b><br>Address  |   |   |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201 Coronary occlusion &amp; fresh myocardial infarction</b><br>DUE TO (b) <b>arteriosclerotic heart disease</b><br>DUE TO (c) <b>hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                   |   |   |  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b><br><b>normal signs</b><br><b>abnormal signs</b> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                   |   |   |  |   |   |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |   |   |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |  |                                   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec 21</b> , 19 <b>65</b> , to <b>Dec 21</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec 21</b> , 19 <b>65</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.   |  |                                   |   |   |  |   |   |   |  |   |  |
| 22a. SIGNATURE <b>Philip J. Hirshman</b>   |  |                                   |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   | 22b. DATE SIGNED <b>12/22/65</b>                                    |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>   |  |                                   |   |   | 22d. ADDRESS <b>159 W. Wash. St., Hag. Md.</b>   |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>  |  | 23b. DATE THEREOF <b>12-24-65</b> |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>   |  |   | 23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b> |   |  |   |  |
| 24. FUNERAL DIRECTOR <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b><br>ADDRESS   |  |                                   |   |   | 25a. REC'D BY REGISTRAR <b>DEC 29 1965</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                     |   |  |   |  |

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STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Washington County, Maryland  
Hagerstown  
320 Myrtle Ave.  
WILLIAM T. TROSBROOK  
JAN. 15, 1911  
White  
Unit Chairman  
George L. Jones  
JAN. 11, 1911  
JAN. 11, 1911

John J. [illegible]  
JAN. 11, 1911  
JAN. 11, 1911  
JAN. 11, 1911

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ~~page 3~~ <sup>page 1</sup> event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

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|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b>   |  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution had residence before admission)<br>a. STATE<br><b>Maryland</b>                                     |  | b. COUNTY<br><b>Washington</b>   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  | c. LENGTH OF STAY IN 1b<br><b>1 Week</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown, Jefferson Heights</b>                                    |  | d. STREET ADDRESS<br><b>319 Greendale Dr.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington County Hospital</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Jacob</b>   |  | First<br><b>Boyd</b>   |  | Last<br><b>Monninger</b>  |  | 4. DATE OF DEATH<br>Month<br><b>December 13,</b> 19 <b>65</b>  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>November 20, 1878</b>   |  |
| 9. AGE (in years last birthday)<br><b>87 yrs.</b>   |  | 10. AGE (in years last birthday)<br><b>0</b>   |  | 11. AGE (in years last birthday)<br><b>23</b>   |  | 12. AGE (in years last birthday)<br><b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer (Retired)</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Upton, Penna.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>Davis Monninger</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Shank</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No.</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Mrs. Della M. Monninger</b>   |  | Address<br><b>319 Greendale Dr. Hagerstown, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br>4221 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (c) <b>Arteriosclerosis Obliterans of left leg.</b> |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 Days</b><br><b>10 yrs.</b>                                   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Arteriosclerosis Obliterans of left leg.</b>   |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  | 20g. (City or town) (County) (State)  |  | 20h. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-12, 1960</b> to <b>12-13, 1965</b> , that (I) (we) last saw the deceased alive on <b>12-13, 1965</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.   |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Charles F. Hess</b>  |  |  |  | 22b. DATE SIGNED<br><b>12-15-65</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Charles F. Hess MD</b>  |  |
| 22d. ADDRESS<br><b>Smithsburg, Md.</b>  |  |  |  | 22e. ADDRESS<br><b>Smithsburg, Md.</b>  |  | 22f. ADDRESS<br><b>Smithsburg, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>12-16-65</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Beaver Creek Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Beaver Creek, Wash. Md.</b>                         |  |
| 24. FUNERAL DIRECTOR<br><b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 20 1965</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |   |   |   |  |  |  |
|---|--|---|--|---|---|---|--|--|--|
| 17059 CERTIFICATE OF DEATH 20441  |  |   |  |   |   |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>3 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>   |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Funkstown</b><br>d. STREET ADDRESS <b>1</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ALTON</b> Middle <b>CECIL</b> Last <b>MOORE</b>   |  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>21</b> Year <b>1965</b> |   |   |   |  |  |  |
| 5. SEX <b>male</b>  |  | 6. COLOR OR RACE <b>white</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>July 23, 1906</b>                            |  | 9. AGE (In years last birthday) <b>59</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>  |   |   | 12. CITIZEN OF WHAT COUNTRY?                     |  |  |
| 13. FATHER'S NAME <b>Alexander N. Moore</b>   |  |   |  |   | 14. MOTHER'S MAIDEN NAME <b>Ida Z. Dixon</b>  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>  |  | 16. SOCIAL SECURITY NO. <b>1925-1928</b>  |  | 17. INFORMANT <b>Mrs. Gladys Andrews, Hagerstown, Md.</b>   |   |   | Address  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA, BILAT.</b><br>490X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic PNEUMONITIS DUE TO PSEUDOMONAS</b> |  |   |  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>15 June</b> , 19 <b>63</b> , to <b>21 Dec.</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>21 Dec.</b> , 19 <b>65</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.   |  |   |  |   |   |   |  |  |  |
| 22a. SIGNATURE <b>W. N. Fender</b>  |  |   |  |   | 22b. DATE SIGNED <b>22 Dec. 65</b>  |   | 22c. PHYSICIAN'S NAME (Type) <b>W. N. Fender</b> |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>   |  | 23b. DATE THEREOF <b>12-23-65</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>  |   | 23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>DEC 28 1965</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                     |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17060

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

20442

|   |  |                                   |  |   |  |  |  |   |  |
|---|--|-----------------------------------|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u><br>c. LENGTH OF STAY IN 1b <u>Life</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>   |  |                                   |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u><br>d. STREET ADDRESS <u>564 Salem Ave.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) First <u>William</u> Middle <u>Columbus</u> Last <u>Morgan</u>   |  |                                   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>16</u> Year <u>1965</u>  |  |  |  |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><u>August 20, 1906</u>                                 |  | 9. AGE (In years last birthday) <u>59</u> yrs.<br>IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>  |  |                                   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>Andrew C. Morgan</u>   |  |                                   |  | 14. MOTHER'S MAIDEN NAME <u>Martha Rohrer</u>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |  |                                   |  | 16. SOCIAL SECURITY NO. <u>214-09-5545</u>  |  | 17. INFORMANT <u>Joe E. Morgan Sr. 2 S. Vermont St. Williamsport, Md.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u><br>163X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO<br>(c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>3-5 wks</u> |  |                                   |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |  |                                   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)     |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/11/65</u> , 19 <u>65</u> , to <u>12/16/65</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/16/65</u> , 19 <u>65</u> , and that death occurred at <u>11:08</u> M, from the causes and on the date stated above.  |  |                                   |  |   |  |  |  |   |  |
| 22a. SIGNATURE <u>John C. Morton</u> M.D.   |  |                                   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  | 22b. DATE SIGNED <u>12/17/65</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>John C. Morton, M.D.</u>  |  |                                   |  | 22d. ADDRESS <u>580 Northern Avenue Hagerstown, Md. 21740</u>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>12/19/65</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Church Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State) <u>Locust Grove Md</u>        |  |   |  |
| 24. FUNERAL DIRECTOR <u>Wm. G. Hov</u>  |  |                                   |  | ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>  |  | 25a. REC'D BY REGISTRAR <u>DEC 20 1965</u>                                 |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Washington</i>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Williamsport</i>   |  | c. LENGTH OF STAY IN 1b<br><i>4 yrs 5 mo 2 days</i>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>Maryland</i> |  | b. COUNTY<br><i>Washington</i>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Williamsport Sanitarium</i>  |  |   |  |   |  | e. STREET ADDRESS<br><i>1139 Hamilton Blvd.</i>  |  | f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><i>Anna Mae Murray</i>   |  |   | 4. DATE OF DEATH<br>Month <i>13</i> Day <i>11</i> Year <i>1950</i> |   |  |  |  |   |  |
| 5. SEX<br><i>Female</i>   |  | 6. COLOR OR RACE<br><i>White</i>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>May 5, 1889</i>   |  | 9. AGE (In years last birthday)<br><i>76</i> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Restaurant Owner</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Restaurant</i>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Marlow, West Va.</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |   |  |
| 13. FATHER'S NAME<br><i>James R. Ripple</i>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Catherine Ardingier</i>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>  |  | 16. SOCIAL SECURITY NO.<br><i>220-44-3255</i>   |  | 17. INFORMANT<br><i>Mr. George Murray</i> Address <i>202 S. Onocochesque St. Williamsport Md.</i>   |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i><br>331X DUE TO <i>Cerebral Arteriosclerosis</i><br>DUE TO <i>Generalized Arteriosclerosis</i><br>DUE TO <i>10-15 yrs</i>         |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>1/2 hour</i><br><i>5 years</i>                             |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <i>19</i>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>10/1</i> , 19 <i>43</i> , to <i>12/11</i> , 19 <i>42</i> , that (I) (we) last saw the deceased alive on <i>11/16</i> , 19 <i>42</i> , and that death occurred at <i>9 AM</i> , from the causes and on the date stated above. |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><i>John C. Mordon</i>   |  |   |  |   |  | 22b. DATE SIGNED<br><i>12/13/45</i>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>John C. Mordon</i>   |  |   |  | 22d. ADDRESS<br><i>Williamsport, Md.</i>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE THEREOF<br><i>Dec. 14-65</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Riverview Cemetery</i>   |  | 23d. LOCATION (City, town or county) (State)<br><i>Williamsport Maryland</i>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Albert L. Leaf</i>   |  |   |  | ADDRESS<br><i>Williamsport Md.</i>  |  | 25a. REC'D BY REGISTRAR<br><i>DEC 15 1965</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                        |  |   |   |   |  |  |  |
|---|--|------------------------|--|---|---|---|--|--|--|
| 17062<br>CERTIFICATE OF DEATH<br>20444  |  |                        |  |   |   |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY Washington<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leidersburg, Hagerstown R.D.<br>c. LENGTH OF STAY IN 1b 5 life<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |                        |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Washington<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Hagerstown R.D.5<br>d. STREET ADDRESS 1<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Arthur M. Myers   |  |                        |  |   | 4. DATE OF DEATH<br>Month Day Year<br>Dec. 5 19 65  |   |  |  |  |
| 5. SEX male   |  | 6. COLOR OR RACE white |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH 3/24/1893  |  | 9. AGE (In years last birthday) 72 yrs.<br>IF UNDER 1 YEAR: Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator  |  |                        | 10b. KIND OF BUSINESS OR INDUSTRY Machine tool |   |   | 11. BIRTHPLACE (County & State, or foreign country) Leidersburg, Md.  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |
| 13. FATHER'S NAME Warren C. Myers   |  |                        |  |   | 14. MOTHER'S MAIEN NAME Mary M. Hovis   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes   |  |                        | 16. SOCIAL SECURITY NO. WW 1                   |   | 17. INFORMANT Mrs. Arthur M. Myers  |   |  | Address Hagerstown, Md. R.D.5  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma - Prostate<br>177X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Osteoarthritis & Hypertensive Heart Disease<br>(c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Inguinal Hernia Rt |  |                        |  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH 9 mo.<br>6 yrs.                                   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                        |  |   |   |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                        |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br>19  |  |                        |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from April 15, 1965, to Dec 5, 1965, that (I) (we) last saw the deceased alive on Nov. 29, 1965, and that death occurred at 5 P.M. from the causes and on the date stated above.   |  |                        |  |   |   |   |  |  |  |
| 22a. SIGNATURE Philip J. Hirshman   |  |                        |  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED 12/7/65   |  |
| 22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.   |  |                        |  |   |   | 22d. ADDRESS 159 West Washington St., Hagerstown, Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |                        | 23b. DATE THEREOF 12/8/1965                    |   | 23c. NAME OF CEMETERY OR CREMATORY St. Paul Lutheran  |   | 23d. LOCATION (City, town or county) (State) Leidersburg, Hagerstown Md. R.D.5 |  |  |
| 24. FUNERAL DIRECTOR Walter J. Grove  |  |                        |  |   |   | ADDRESS Waynesboro, Pa.   |  | 25a. REC'D BY REGISTRAR DEC 9 1965   |  |
|   |  |                        |  |   |   | 25b. REGISTRAR'S SIGNATURE J. Charles Judge   |  |  |  |

STATE DEPARTMENT OF HEALTH  
BUREAU OF STATISTICS  
CERTIFICATE OF DEATH

1922

DATE OF DEATH: . . . . .  
PLACE OF DEATH: . . . . .  
CAUSE OF DEATH: . . . . .  
MANNER OF DEATH: . . . . .  
AGE: . . . . .  
SEX: . . . . .  
RACE: . . . . .  
BIRTH: . . . . .  
MARRIAGE: . . . . .  
OCCUPATION: . . . . .  
EDUCATION: . . . . .  
RELIGION: . . . . .  
SOCIETY: . . . . .  
FAMILY: . . . . .  
CITY: . . . . .  
COUNTY: . . . . .  
STATE: . . . . .

1

1922



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |  |  |  |   |  |  |   |  |
|--|--|--|--|--|---|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>WASHINGTON</b> MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HANCOCK</b><br>c. LENGTH OF STAY IN 1b <b>LIFE</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RFD# 2 HANCOCK</b>   |  |  |  |  | <b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b><br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HANCOCK</b><br>d. STREET ADDRESS <b>RFD# 2 HANCOCK</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <b>ROY PANTELON MYERS</b><br>First Middle Last<br><b>4. DATE OF DEATH</b> Month <b>DECEMBER</b> Day <b>20</b> Year <b>19 65</b>   |  |  |  |  | <b>5. SEX</b> <b>MALE</b><br><b>6. COLOR OR RACE</b> <b>WHITE</b><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <b>7/25/1889</b><br><b>9. AGE (In years last birthday)</b> <b>76</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.                |  |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CONSTRUCTION</b>   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>FULTON CO. PENNA.</b>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>                                    |   |  |
| <b>13. FATHER'S NAME</b> <b>SHERMAN G. MYERS</b>   |  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b> <b>AMANDA SHIVES</b>  |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>   |  |  | <b>16. SOCIAL SECURITY NO.</b> <b>219-12-0960</b>  |  | <b>17. INFORMANT</b> <b>MARY V. MYERS</b> Address <b>RFD#2 HANCOCK MD.</b>  |  |  |   |  |
| <b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b><br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b><br>(b) <b>Cardio Vasc disease</b><br>(c) <b>4201</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 days</b> |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>  |  |  |  |  |   |  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town) (County) (State)</b>  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from <u>1960</u>, 19<u>  </u>, to <u>Dec. 20</u>, 19<u>65</u>, that (I) (we) last saw the deceased alive on <u>12/20</u>, 19<u>65</u>, and that death occurred at <u>11:10</u> AM, from the causes and on the date stated above.</b>                     |  |  |  |  |   |  |  |   |  |
| <b>22a. SIGNATURE</b> <i>L.M. Shaffer</i>  |  |  |  |  | <b>22b. DATE SIGNED</b>   |  |  |   |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b> <b>L.M. SHAFFER</b>  |  |  |  |  | <b>22d. ADDRESS</b> <b>HANCOCK MD.</b>  |  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>   |  |  | <b>23b. DATE THEREOF</b> <b>12/23/1965</b>   |  | <b>23c. NAME OF CEMETERY</b> <b>MT. ZION LUTHERAN</b>   |  | <b>23d. LOCATION (City, town or county) (State)</b> <b>FRANKLIN CO. PENNSYLVANIA</b> |   |  |
| <b>24. FUNERAL DIRECTOR</b> <b>HANCOCK, MARYLAND</b>   |  |  |  |  | <b>25a. REC'D BY REGISTRAR</b> <b>DEC 27 1965</b>   |  | <b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>                               |   |  |

WASHINGTON MARYLAND WASHINGTON

RURAL HANDOOK LIFE RURAL HANDOOK

RED S. HANDOOK RED S. HANDOOK

BOY PAINTLON VETS DECEMBER

MALE WHITE 2/22/1889 26

CARPENTER CONSTRUCTION FULTON CO. PENNA. U.S.A.

SHERMAN G. MYERS AMANDA SHIVERS

210-1-0000 MAY V. MYERS RED S. HANDOOK NO.

BURIAL 12/23/1962 MT. Zion LUTHERAN FRANKLIN CO. PENNSYLVANIA

HANOOK, MARYLAND

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u><br>c. LENGTH OF STAY IN 1b <u>1 day</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural X Clearspring RFD #1</u><br>d. STREET ADDRESS <u>1</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First <u>William</u> Middle <u>Albert</u> Last <u>Nave</u>   |                               | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>26</u> Year <u>1965</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>July 29 1899</u>             |
| 9. AGE (In years last birthday) <u>66</u> yrs.  |                               | IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>27</u> Hours <u>27</u> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concrete Finisher</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>   |  |
| 13. FATHER'S NAME <u>Bradley Nave</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Ella Teach</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>217-03-3300</u>  |  |
| 17. INFORMANT <u>Mr. Albert F. Nave</u>   |                               | Address <u>Hagerstown, Md. 1919 Va. Ave.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fractured Skull With Acute Subdural Hematoma</u><br>9035 DUE TO (b) <u>Cerebral Lacerations</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____  |                               |   | INTERVAL BETWEEN ONSET AND DEATH <u>21 hours</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                               |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Fell on pavement Cor. Jonathan &amp; Bethel Street (intoxicated)</u>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>6 12-25- 1965</u> Hour a.m. <u>6</u>  |                               | 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input checked="" type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>  |                               | 20f. (City or town) <u>Hagerstown, Washington, Md.</u> (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                               |   |  |
| ACTUAL SIGNATURE <u>[Signature]</u>   |                               | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>  |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-27-65</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>Dec. 29 1965</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>  |                               | 23d. LOCATION (City, town or county) <u>Williamsport Md.</u> (State)  |  |
| 24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Md.</u>   |                               | 25a. REC'D BY REGISTRAR <u>DEC 28 1965</u> DATE   |  |
|   |                               | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b<br><b>1 Week</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington County Hospital</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Boonsboro</b><br>d. STREET ADDRESS<br><b>207 N. Main St.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Charles Ellsworth Needy</b>   |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>29</b> Year <b>1965</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>October 1, 1885</b>                                    |
| 9. AGE (In years last birthday)<br><b>80 yrs.</b>   |                                  | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>28</b> Hours <b></b> Min. <b></b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>White Hall, Md.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                  | 13. FATHER'S NAME<br><b>David H. Needy</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary Griffin</b>   |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No.</b>  |   |
| 16. SOCIAL SECURITY NO.<br><b>219-12-2127</b>   |                                  | 17. INFORMANT<br><b>Mrs. Mary C. Needy</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic congestive heart failure</b><br><b>4200</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>arteriosclerotic heart failure.</b><br>DUE TO (c) <b></b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b></b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>June 1960</b>   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b></b>   |                                  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b></b>   |   |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b></b>  |   |
| 20f. (City or town) (County) (State)<br><b></b>   |                                  | 21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 1960, to <b>Dec 29</b> , 1960, that (I) (we) last saw the deceased alive on <b>12-29-1960</b> , and that death occurred at <b>5:30</b> M., from the causes and on the date stated above.   |   |
| 22a. SIGNATURE<br><b>J. H. Secordari</b>  |                                  | 22b. DATE SIGNED<br><b>12-30-65</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOSEPH SECORDARI</b>   |                                  | 22d. ADDRESS<br><b>Boonsboro Md</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>1-2-66</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Boonsboro Cemetery</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Boonsboro, Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>1966</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  |  |   |

1944

Washington, Maryland, Georgetown

Washington County Hospital, I have, Georgetown

October 1, 1944, SOY E. Main St.

October 1, 1944, Georgetown, Md.

October 1, 1944, Georgetown, Md.

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October 1, 1944, Georgetown, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17066 CERTIFICATE OF DEATH 20448

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X rural Hagerstown</b>                       |  |
| c. LENGTH OF STAY IN 1b<br><b>20 years</b>  |  | d. STREET ADDRESS<br><b>Rd # 1</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington County Hospital</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>CHARLES EDWARD NEWCOMER</b>   |  | 4. DATE OF DEATH<br><b>Dec. 29 1965</b>   |  |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>white</b>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>Jan. 30 1893</b>   |  |
| 9. AGE (In years last birthday)<br><b>72 yrs.</b>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>driver</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Beaver Creek Md.</b>  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>baking co.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>Martin Newcomer</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Betty McCauley</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes WW 1</b>  |  | 16. SOCIAL SECURITY NO.<br><b>219-20-3954</b>   |  |
| 17. INFORMANT<br><b>Susan Newcomer</b>  |  | Address<br><b>Rd. #1 Hag. Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant Pulmonary Embolism</b><br><b>465x</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Hypertensive Cardio Vasc. D.</b><br>DUE TO (c) <b>arterio-sclerotic Heart D.</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12-23-65</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic Pyelo-nephritis</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                           |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov 18 -</b> , 19 <b>64</b> , to <b>Dec 29</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec 28</b> , 19 <b>65</b> , and that death occurred at <b>1:15 P.M.</b> , from the causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><b>Sidney Novenstein</b>  |  | 22b. DATE SIGNED<br><b>12-29-65</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>SIDNEY NOVENSTEIN</b>  |  | 22d. ADDRESS<br><b>FUNKSTOWN MD</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>cremation</b>   |  | 23b. DATE THEREOF<br><b>12-31-65</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Washington, D. C.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Scott F. Minnich &amp; Son Hag. Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 3 1966</b>  |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |  |

48-105

CERTIFICATE OF DEATH

10

Washington County, Maryland  
Date of Death: Jan. 20, 1961  
Age: 50 years  
Sex: Male  
Race: White  
Marital Status: Single  
Cause of Death: Heart Disease  
Place of Death: Home  
Signature: [Signature]  
Date: Jan. 20, 1961

— Washington County, Maryland  
— State of Maryland

George F. [Signature]

George F. [Signature]  
[Signature]  
[Signature]

10-21-61  
George F. [Signature]  
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |                               |  |                                  |
|--|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b><br>d. STREET ADDRESS <b>RT. #6</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 3. NAME OF DECEASED (Type or print) <b>RUDOLPH A. OELMANN</b>  |                               | 4. DATE OF DEATH <b>DECEMBER 22 1965</b>   |                                  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>6/8/1886</b> |
| 9. AGE (in years last birthday) <b>79</b> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret-conveyer</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Amer. Brewery</b>   |                                  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?   |                                  |
| 13. FATHER'S NAME <b>Albert Oelmann</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                               | 16. SOCIAL SECURITY NO. <b>216-01-4468</b>   |                                  |
| 17. INFORMANT <b>Walter R. Oelmann, son, above</b>   |                               | Address  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b><br>4500 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gen'l arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b><br>yrs. |                               |  |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> , 19 <b>55</b> , to <b>Dec. 22</b> , 19 <b>65</b> that (I) (we) last saw the deceased alive on <b>Dec. 21, 1965</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.  |                               |  |                                  |
| 22a. SIGNATURE <b>Howard N. Weeks</b>  |                               | 22b. DATE SIGNED <b>12/22/65</b>   |                                  |
| 22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M. D.</b>   |                               | 22d. ADDRESS <b>580 Northern Ave., Hagerstown Maryland</b>   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                               | 23b. DATE THEREOF <b>12/24/65</b>  |                                  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>  |                               | 23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>   |                                  |
| 24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane</b>  |                               | 25a. REC'D BY REGISTRAR <b>DEC 27 1965</b><br>DATE   |                                  |
| 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |                               |  |                                  |

22-27

50-15

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON COUNTY HOSPITAL

RT. 2

HUTCHINS

OLIVER

WASHINGTON

MALE

WHITE

X

6781880

73

1922-CONVOY

1922. 12-27

1922. 12-27

Albert Oliver

Unknown

1922-01-24-28

1922-01-24-28

1922-01-24-28

1922-01-24-28

*Handwritten signature*

1922-01-24-28

1922-01-24-28

1922-01-24-28

1922-01-24-28

1922-01-24-28

1922-01-24-28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |                          |   |  |   |  |   |   |  |  |
|---|--|--|--------------------------|---|--|---|--|---|---|--|--|
| CERTIFICATE OF DEATH  |  |  |                          |   |  |   |  |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>WASHINGTON</b>   |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>RURAL BOONSBORO</b> |                          | c. LENGTH OF STAY IN 1b<br><b>4 YRS.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>            |  | b. COUNTY<br><b>WASHINGTON</b>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>RURAL BOONSBORO</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>FAHRNEY-KEEDY HOME</b>   |  |  |                          |   |  | d. STREET ADDRESS<br><b>NONE</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>EDITH</b>   |  |  | First<br><b>SHEPHERD</b> |   |  | Middle<br><b>OTIS</b>   |  |   | Last<br><b>OTIS</b>                           |  |  |
| 4. DATE OF DEATH<br><b>DECEMBER</b>   |  | Month<br><b>8</b>  |                          | Day<br><b>19</b>  |  | Year<br><b>65</b>   |  |   |   |  |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>   |                          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>AUG. 24, 1881</b>  |  | 9. AGE (In years last birthday)<br><b>84 yrs.</b>   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOMEMAKER</b>   |  |  |                          | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>PROVIDENCE CO., RHODE ISLAND</b>                                      |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |  |
| 13. FATHER'S NAME<br><b>EDWARD H. SHEPHERD</b>  |  |  |                          |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE FRANCIS</b>  |  |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  |  |                          | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT<br><b>MRS. CHARLES WAGAMAN</b>  |  | HAGERSTOWN, MD.<br><b>740 PRESTON RD.</b>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral atherosclerosis</b><br><b>334X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized atherosclerosis</b><br>(c) <b>Coronary atherosclerosis; previous carcinoma of breast, cervix.</b> |  |  |                          |   |  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Coronary atherosclerosis; previous carcinoma of breast, cervix.</b>   |  |  |                          |   |  |   |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                          | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |  |                          | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Aug 31</b> , 19 <b>54</b> , to <b>Dec 8</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec 8</b> , 19 <b>65</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.  |  |  |                          |   |  |   |  |   |   |  |  |
| 22a. SIGNATURE<br><b>Lawrence L. Packer, Jr.</b>  |  |  |                          |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>12/9/1965</b>  |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>LAWRENCE L. PACKER, JR. M.D.</b>   |  |  |                          |   |  | 22d. ADDRESS<br><b>145 W. WASHINGTON ST. HAGERSTOWN, MD.</b>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   |  | 23b. DATE THEREOF<br><b>DEC. 8, 1965</b>   |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SWAN POINT CEMETERY</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>PROVIDENCE, RHODE ISLAND</b>   |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Charles M. Rouse</b>   |  |  |                          |   |  | ADDRESS<br><b>HAGERSTOWN, MARYLAND</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 13 1965</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

CERTIFICATE OF DEATH

1962

WASHINGTON, DISTRICT OF COLUMBIA  
RURAL, ROCKFORD, ILL.  
FATHER: RICHARD J. RYAN  
MOTHER: MARY ANN RYAN  
DATE OF BIRTH: AUG. 24, 1901  
PLACE OF BIRTH: ROCKFORD, ILL.  
EDWARD H. RYAN, JR.  
FATHER: RICHARD J. RYAN  
MOTHER: MARY ANN RYAN  
DATE OF BIRTH: AUG. 24, 1901  
PLACE OF BIRTH: ROCKFORD, ILL.

12/1/62  
MANHATTAN, N.Y.  
DEC. 1, 1962  
HARRINGTON, WYOMING  
DEC. 1, 1962



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17069

20451

|   |                           |   |                                   |  |  |
|---|---------------------------|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Washington  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>Maryland   |                                   | b. COUNTY<br>Washington  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hagerstown  |                           | c. LENGTH OF STAY IN 1b<br>2 1/2 hrs.   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>X Rural Williamsport Md. |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Washington County Hospital  |                           |   |                                   | d. STREET ADDRESS<br>Pinesburg   |  |
| 3. NAME OF DECEASED (Type or print)<br>Hollie Allen Palmer  |                           | 4. DATE OF DEATH<br>December 29, 1965   |                                   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>April 17 1937 | 9. AGE (In years last birthday)<br>28 yrs. 8 1/2 months 11 days 11 min.                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Manager Frozen Foods Food Market   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Food Market  |                                   | 11. BIRTHPLACE (State or foreign country)<br>Pinesburg Md.   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                           | 13. FATHER'S NAME<br>Holly Palmer   |                                   |  |  |
| 14. MOTHER'S MAIDEN NAME<br>Leona May Palmer  |                           | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>No   |                                   |  |  |
| 16. SOCIAL SECURITY NO.<br>214 34 9662  |                           | 17. INFORMANT<br>Mr. John Eby Williamsport Md. RFD #2   |                                   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fractured Skull With Multiple Lacerations</u><br>DUE TO (b) <u>Fracture Of All Bones Of The Face With Multiple Lacerations</u><br>DUE TO (c) <u>Fracture Of Right Leg</u><br>8104   |                           |   |                                   | INTERVAL BETWEEN ONSET AND DEATH<br>2 1/2 hours  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>Driver of car in collision with Wm. R. R. train at Williamsport, Md., crossing.  |                           |   |                                   |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           | 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                |                                   |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>Wm. R. R. train at Williamsport, Md., crossing.   |                           | 20c. TIME OF INJURY Month, Day, Year<br>7:15 p.m. 12-29-1965  |                                   |  |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |                           | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>State Route 68 Williamsport, Washington, Md.                                      |                                   |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |   |                                   |  |  |
| ACTUAL SIGNATURE<br>[Signature]   |                           | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                   | 22. DATE SIGNED<br>12-29-65  |  |
| EXAMINER'S NAME (Type)<br>D.R. E. W. Ditto, Jr.   |                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                   | Address (Street, city, town, or county)<br>Hagerstown, Md.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 23b. DATE THEREOF<br>Jan. 1-66  |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mennonite Cemetery   |  |
| 23d. LOCATION (City, town or county)<br>Williamsport Md.  |                           | 23e. REC'D BY REGISTRAR<br>JAN 3 1966   |                                   | 23f. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

1151

MECHANICAL EXAMINERS' CERTIFICATE OF DEATH

1151

December 22

Palmer

1151

2 hours

Fractured Skull with Multiple Lacerations

Fracture of Left Jaw

Lacerations

Fracture of Right Jaw

Driver of car in collision with

W. L. Smith at Millington, W. J. Co., Tenn.

W. L. Smith at Millington, W. J. Co., Tenn.

7:30 12-22-22

x

x

12-22-22

Memphis, Tenn.

W. L. Smith, Jr.

1151

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20452

|   |                                       |   |   |
|---|---------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u>  |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Williamsport</u>   |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Williamsport RFD #2</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>W. Md. R. R. Crossing</u>  |                                       | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Leona</u> Middle <u>May</u> Last <u>Palmer</u>  |                                       | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>29</u> Year <u>1965</u>  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 23 1916</u>                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Dish Washer</u>   |                                       | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Restaurant</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Williamsport Md. RFD 2</u>  |                                       | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>George M. Corderman</u>   |                                       | 14. MOTHER'S MAIDEN NAME<br><u>Cornelia J. Trumpower</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                       | 16. SOCIAL SECURITY NO.<br><u>220 26 6137</u>   |   |
| 17. INFORMANT<br><u>Mr. John Eby Williamsport Md. RFD 2</u>   |                                       | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fracture Of Skull With Facial Lacerations</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Crushing Injury To Chest</u><br>DUE TO<br>(c) <u>Fracture Of Both Arms And Legs</u>   |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><u>Instant</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Passenger in car in collision with</u>  |                                       | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.   |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br><u>Wm. R. R. train at Williamsport, Md. crossing.</u>       |   |
| 20c. TIME OF INJURY Month, Day, Year<br><u>7:15 PM 12-29-1965</u>   |                                       | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>State Route 68 Williamsport, Washington, Md.</u>   |                                       | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                       |   |   |
| ACTUAL SIGNATURE<br><u>[Signature]</u>  |                                       | 22. DATE SIGNED<br><u>12-29-65</u>  |   |
| EXAMINER'S NAME (Type)<br><u>Dr. E. W. Ditto, Jr.</u>   |                                       | Address (Street, city, town, or county)<br><u>Hagerstown, Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>Jan. 1-66</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mennonite Cemetery</u>   | 23d. LOCATION (City, town or county) (State)<br><u>Williamsport Md. RFD 2</u> |
| 24. FUNERAL DIRECTOR<br><u>Albert L. Leaf Williamsport Md.</u>  |                                       | 25a. REC'D BY REGISTRAR<br><u>JAN 3 1966</u>  |   |
|   |                                       | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |

20452

070

December 29, 1941

Truck of Skull with Isot. Laboratory

Containing Injury to Joint

Truck of Bone from And Isot.

Truck in car in collision with

W.R. R. train at Williamsport, Pa., crossing.

7:12 - 12-29 - 1941 State Route 99 Williamsport, Washington, D.C.

x

x

12-29-41

Williamsport, Pa.

Williamsport, Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>1 DAY</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>rr 214 N. POTOMAC STREET</b>  |  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b><br>d. STREET ADDRESS <b>1 23 W. WASHINGTON STREET</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>JOHN</b> <b>EDWARD</b> <b>PATTON</b>   |  |  | 4. DATE OF DEATH <b>DECEMBER 17 1965</b>  |  | 5. SEX <b>MALE</b>   |   | 6. COLOR OR RACE <b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 8. DATE OF BIRTH <b>DEC. 28, 1894</b>   |  |  | 9. AGE (In years last birthday) <b>70</b> yrs.  |  | IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.   |   | IF UNDER 24 HRS.   |  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BRAKEMAN</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>   |  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b> |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |  |
| 13. FATHER'S NAME <b>JOHN W. PATTON</b>   |  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>ELLA TICE</b>  |   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>  |  |  | 16. SOCIAL SECURITY NO. <b>W.W.I 705-10-7423</b>  |  | 17. INFORMANT <b>HAGERSTOWN, MD. MRS. FRANCES PHETTEPLACE R.D. #1</b>  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4200 Unborn Infant In Uterus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis in Heart Dis.</b><br>(c) <b>Generalized Arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |  |   |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 m.d.</b><br><b>7-10 yrs.</b><br><b>15 yrs.</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                     |  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-7-60</b> , 19 <b>1960</b> to <b>12/17/65</b> , 19 <b>1965</b> , that (I) (we) last saw the deceased alive on <b>6-26-65</b> , 19 <b>1965</b> , and that death occurred at <b>12 2019</b> M, from the causes and on the date stated above.  |  |  |   |  |  |   |  |  |  |   |  |
| 22a. SIGNATURE <b>John C. Morton</b>  |  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |   | 22b. DATE SIGNED <b>12/18/1965</b>                                       |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>JOHN C. MORTON M.D.</b>   |  |  |   |  | 22d. ADDRESS <b>580 NORTHERN AVE. HAGERSTOWN, MD.</b>  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |  | 23b. DATE THEREOF <b>DEC. 20, 1965</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>   |   | 23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b> |  |  |   |  |
| 24. FUNERAL DIRECTOR <b>Charles M. Royce</b> <b>HAGERSTOWN, MARYLAND</b>  |  |  |   |  | 25a. REC'D BY REGISTRAR <b>DEC 27 1965</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                          |  |  |   |  |



50-103

1000

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

1 MAY

WASHINGTON

23 W. WASHINGTON STREET

17 1/2 W. POTOMAC STREET

JOHN EDWARD PATTON

DECEMBER 17

MALE WHITE

DOB. 28, 1906

RETIRING BARRMAN RAILROAD WASHINGTON CO., MARYLAND U.S.A.

JOHN A. PATTON

BILL TYPE

HARRINGTON, MD.

YES W.A.I. 707-10-7003 MRS. FRANCES PRITCHARD, U.S.A.

12/17/1906

JOHN C. KORTON B.D. 300 NORTHERN AVE., WASHINGTON, D.C.

JOHN C. KORTON B.D.

HARRINGTON, MARYLAND

DEC. 20, 1906 1003 BELL STREET

UNIT

HARRINGTON, MARYLAND



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

91

06

02

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>   |  |   |  |  |   |   |  |  |   |  |
|--|--|---|--|--|---|---|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. CDUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u> <span style="float: right;">3 Months</span><br>c. LENGTH OF STAY IN 1b  |  |   |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Maryland</u> <span style="float: right;">b. CDUNTY <u>Carroll</u></span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Woodbine</u> <span style="float: right;">06 X. 2</span><br>d. STREET ADDRESS <u>R.F.D. # 1</u> |   |  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>E. DEWEY PICKETT</u><br>First Middle Last   |  |   |  |  | <b>4. DATE OF DEATH</b><br><u>Dec. 20 19 65</u><br>Month Day Year   |   |  |  |   |  |
| <b>5. SEX</b><br><u>Male</u>   |  | <b>6. COLOR OR RACE</b><br><u>White</u> |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDDED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |   | <b>8. DATE OF BIRTH</b><br><u>Jan. 16 1898</u>                      |  | <b>9. AGE</b> (In years last birthday) <u>67</u> yrs.<br>IF UNDER 1 YEAR: Months Days Hours Min. |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Retired Farmer</u>  |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Farming</u>   |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Maryland</u> |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>   |   |  |
| <b>13. FATHER'S NAME</b><br><u>Harvey E. Pickett</u>   |  |   |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Florence Conaway</u>  |   |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  |   |  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>None</u>   |   |  |  |   |  |
| <b>17. INFORMANT</b><br><u>Mrs Bertha P. Pickett</u>   |  |   |  |  | <b>Address</b><br><u>Same as # 2</u>  |   |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) <u>Bilateral lobular pneumonia</u><br>9040<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Complications - fracture left femur</u><br>DUE TO (c) <u>fracture</u><br><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><u>Paralytic Agitation</u> |  |   |  |  |   |   |  |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |   |   |  |  |   |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/><br><b>CAUSE OF DEATH.</b>   |  |   |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><u>Fell in Basement of Home</u>  |   |  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br><u>?? a.m. Sept 25 19 65</u><br><u>?? p.m.</u>  |  |   |  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u> |  | <b>20f. (City or town (State))</b><br><u>Woodbine (Carroll) Md.</u>           |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>   |  |   |  |  |   |   |  |  |   |  |
| <b>ACTUAL SIGNATURE</b> <u>Edward W. Dittus</u><br><b>EXAMINER'S NAME (Type)</b> <u>Edward W. Dittus</u><br><u>212 W. Washington St Hagerstown</u>   |  |   |  |  | <b>22. DATE SIGNED</b><br><u>12-20-65</u><br><b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>   |   |  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  |   |  |  | <b>23b. DATE THEREOF</b><br><u>Dec. 23 1965</u>   |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Winfield Church of God</u>                   |  | <b>23d. LOCATION (City, town or county) (State)</b><br><u>Carroll Co. Md.</u> |  |
| <b>24. FUNERAL DIRECTOR</b><br><u>C.M. Waltz</u>   |  |   |  |  | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 23 1965</u>  |   | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>                                    |  |   |  |

THE STATE OF  
NEW YORK

11075

IN SENATE  
JANUARY 1, 1907

5000

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 1, 1907

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |  |   |   |  |  |   |  |
|---|--|-------------------------------|--|---|---|--|--|---|--|
| 17073 CERTIFICATE OF DEATH 20455  |  |                               |  |   |   |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>LIFE</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>   |  |                               |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b><br>d. STREET ADDRESS <b>1 31 E. WASHINGTON ST.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>VADA</b> Middle <b>VIRGINIA</b> Last <b>POFFENBERGER</b>  |  |                               |  |   | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>11</b> Year <b>1965</b>  |  |  |   |  |
| 5. SEX <b>FEMALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>2/14/1908</b>  |  | 9. AGE (In years last birthday) <b>57</b> yrs.<br>IF UNDER 1 YEAR: Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min. <b>57</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>  |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>   |   | 11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>          |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>RESIN B. TURNER</b>  |  |                               |  |   | 14. MOTHER'S MAIDEN NAME <b>GRACE V. BYRON</b>  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  |                               |  | 16. SOCIAL SECURITY NO. <b>220-16-3535</b>  |   | 17. INFORMANT <b>MR. JOSUA POFFENBERGER</b><br>Address <b>HAGERSTOWN MD.</b> |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Abdominal carcinomatosis</b><br>1551<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of gall bladder</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                               |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b><br><b>6 months</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8/11</b> , 19 <b>65</b> , to <b>12/11</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12/10</b> , 19 <b>65</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.  |  |                               |  |   |   |  |  |   |  |
| 22a. SIGNATURE <b>George Jennings</b>   |  |                               |  | 22b. DATE SIGNED <b>12/13/65</b>  |   | 22c. PHYSICIAN'S NAME (Type) <b>George Jennings</b>                          |  |   |  |
| 22d. ADDRESS <b>318 N. Potomac St. Hagerstown, Md.</b>  |  |                               |  | 22e. REC'D BY REGISTRAR <b>DEC 16 1965</b>  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |                               |  | 23b. DATE THEREOF <b>12/13/65</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>                    |  | 23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>  |  |
| 24. FUNERAL DIRECTOR <b>W.J. Norman, Hagerstown, Md.</b>  |  |                               |  | 24a. ADDRESS <b>Hagerstown, Md.</b>   |   | 24b. REC'D BY REGISTRAR <b>DEC 16 1965</b>                                   |  | 24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |

20152

WASHINGTON

MARYLAND

WASHINGTON

HAGERSTOWN

LIFE

HAVERSTOWN

31 E. WASHINGTON ST.

WASHINGTON COUNTY HOSPITAL

DECEMBER 11-68

PORTSMOUTH VIRGINIA

YADA

2/1-1908

PEMAKE WHITE

U.S.A.

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BOLE

BOULEWHITE

HAVERSTOWN

GRACE V. SYMON

WILLIAM B. THOMAS

220-16-3532 HA. JOURNAL PORTSMOUTH

6 months  
6 months

Additional circumstances  
Circumstances of your death

62

19/10

62

8/11

62

13/10

13/13/62

Hagerstown, MD  
31 E. Washington St.

George Tennings  
George Tennings

HAGERSTOWN MD.

31 E. WASHINGTON ST.

12/12/68

BURIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified of the death of the deceased, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>4 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Md. State Hospital</b>  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>d. STREET ADDRESS <b>143 Belview Ave</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Tunis Dewey Pryor</b><br>First Middle Last<br>4. DATE OF DEATH <b>Dec. 1, 1965</b><br>Month Year<br>5. SEX <b>male</b><br>6. COLOR OR RACE <b>white</b><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  |  |  |  |  | 8. DATE OF BIRTH <b>June 15, 1897</b><br>9. AGE (In years last birthday) <b>68</b> yrs.<br>IF UNDER 1 YEAR: Months Days Hours Min.<br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b><br>10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |  |  |  |  |  |
| 13. FATHER'S NAME <b>Rooklyn W. Pryor</b>   |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Elsie Brandenburg</b>   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b><br>16. SOCIAL SECURITY NO. <b>417-03-1182</b>   |  |  |  |  |  | 17. INFORMANT <b>Hagerstown, Md.</b><br><b>S.W. Weagley, 143 Belview Ave.</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br>4200<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) acute + chronic pyelonephritis 2) Polynucleosis</b><br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19<br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that (I) (this hospital) attended the deceased from <b>March 8, 1962</b> to <b>Dec. 1, 1965</b> , that (I) <del>was</del> last saw the deceased alive on <b>December 1, 1965</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.<br>22a. SIGNATURE <b>Victor L. Ramos, M.D.</b><br>22b. DATE SIGNED <b>Dec. 2, 1965</b><br>22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b><br>22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Maryland</b><br>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b><br>23b. DATE THEREOF <b>Dec. 5, 1965</b><br>23c. NAME OF CEMETERY OR CREMATORY <b>United Brethren</b><br>23d. LOCATION (City, town or county) (State) <b>Garfield Fred. Co. Md.</b><br>24. FUNERAL DIRECTOR <b>Paul F. Bittle</b><br>24a. REC'D BY REGISTRAR <b>DEC 6 1965</b><br>24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |  |  |  |  |  |   |  |  |  |  |  |

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James Henry Pope  
June 12 1997 62

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Geometrical Proof Unit  
Geometrical, General

(a) state a chronic photograph of the unit

December 62  
March 62 Dec 1 62

Victor L. James, MD  
Victor L. James, MD  
Victor L. James, MD

Victor L. James, MD  
Victor L. James, MD  
Victor L. James, MD

DEC 11 1962



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17075 CERTIFICATE OF DEATH 20457

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u><br>c. LENGTH OF STAY IN 1b <u>Life</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown,</u><br>d. STREET ADDRESS <u>105 E. Washington St.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Thomas</u> Middle <u>Casey</u> Last <u>Rainey Jr.</u>   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>28</u> Year <u>1965</u>   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>April 26, 1964</u>   |  |
| 9. AGE (In years last birthday) <u>1</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>28</u> Hours <u>19</u> Min. <u>65</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Thomas Casey Rainey, Sr.</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Suzanne Reed</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT <u>Mr. J.C. Rainey Sr.</u>  |  | Address <u>Hagerstown, Md.</u><br><u>105 E. Washington St.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Waterhouse Friderichsen Syndrome</u><br>DUE TO (b) <u>Meningococccemia, fulminating</u><br>DUE TO (c) <u>None</u><br>Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last, (c) |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>none</u>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>none</u> p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>none</u>   |  | 20f. (City or town) (County) (State)<br><u>- - -</u>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 14</u> , 196 <u>4</u> , to <u>Dec 28</u> , 196 <u>5</u> , that (I) (we) last saw the deceased alive on <u>Dec 28</u> , 196 <u>5</u> , and that death occurred at <u>A.M.</u> , from the causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE<br><u>Harold R. Tritch, Jr.</u>  |  | 22b. DATE SIGNED<br><u>12-29-65</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. Harold R. Tritch, Jr M.D.</u>  |  | 22d. ADDRESS<br><u>302 N. Potomac St Hagerstown, Md</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>12/30/65</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rest Haven Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>Hagerstown Md.</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>Wm. A. Harsh</u>   |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  | DATE<br><u>JAN 3 1966</u>  |  |

*[Faint handwritten signature]*

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17076

20458

|  |      |   |      |  |  |        |      |       |      |  |  |   |  |
|--|------|---|------|--|--|--------|------|-------|------|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u><br>c. LENGTH OF STAY IN 1b<br><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Washington County Hospital</u> |      |   |      | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>X <u>Rural Boonsboro</u><br>d. STREET ADDRESS<br><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |        |      |       |      |  |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>Bessie Mae Reeder</u>  |      | <b>4. DATE OF DEATH</b><br>Month <u>12</u> Day <u>28</u> Year <u>1965</u>   |      | <b>5. SEX</b><br><u>female</u>   |  |        |      |       |      |  |  |   |  |
| <b>6. COLOR OR RACE</b><br><u>white</u>  |      | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |      | <b>8. DATE OF BIRTH</b><br><u>Sept. 2, 1884</u>  |  |        |      |       |      |  |  |   |  |
| <b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>  |      | IF UNDER 1 YEAR   |      | IF UNDER 24 HRS.   |  | Months | Days | Hours | Min. | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>housewife</u> |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>own home</u> |  |
| IF UNDER 1 YEAR  |      | IF UNDER 24 HRS.  |      |  |  |        |      |       |      |  |  |   |  |
| Months   | Days | Hours   | Min. |  |  |        |      |       |      |  |  |   |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Frederick Co., Md.</u>  |      | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>  |      | <b>13. FATHER'S NAME</b><br><u>John Sigler</u>   |  |        |      |       |      |  |  |   |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><u>Sarah Jones</u>  |      | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |      | <b>16. SOCIAL SECURITY NO.</b><br><u>none</u>  |  |        |      |       |      |  |  |   |  |
| <b>17. INFORMANT</b><br><u>Mrs. Frederick Otto, Boonsboro, Md.</u>   |      | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>DUE TO (b) <u>Cardiac Failure</u><br>(c) <u>Arteriosclerotic Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |      | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 day</u>   |  |        |      |       |      |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |      |   |      |  |  |        |      |       |      |  |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |      | <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>  |      |  |  |        |      |       |      |  |  |   |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |      | <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |      |  |  |        |      |       |      |  |  |   |  |
| <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |      | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |      | <b>20f. (City or town) (County) (State)</b>  |  |        |      |       |      |  |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from <u>12/23/65</u>, 19... to <u>12/28/65</u>, 19..., that (I) (we) last saw the deceased alive on <u>12/27/65</u>, 19..., and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.</b>   |      |   |      |  |  |        |      |       |      |  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Robert V. Campbell</u>   |      | <b>22b. DATE SIGNED</b><br><u>12/28/65</u>  |      | <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Robert V. Campbell</u>   |  |        |      |       |      |  |  |   |  |
| <b>22d. ADDRESS</b><br><u>HAGERSTOWN Md</u>  |      | <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>burial</u>   |      |  |  |        |      |       |      |  |  |   |  |
| <b>23b. DATE THEREOF</b><br><u>12/30/65</u>  |      | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Reformed Cemetery</u>   |      | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Middletown, Md.</u>  |  |        |      |       |      |  |  |   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Gladhill Company, Middletown, Md.</u>  |      | <b>25a. REC'D BY REGISTRAR</b><br><u>Jan 3 1966</u>   |      | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>  |  |        |      |       |      |  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CLASSIFICATION OF DATA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

17077

20459

|  |                                  |   |   |   |  |   |  |
|--|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |                                  |   |   | c. LENGTH OF STAY IN 1b<br><u>1 day</u>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington County Hospital</u>  |                                  |   |   | d. STREET ADDRESS<br><u>Preston Ave.</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Nevin</u> Middle <u>Duane</u> Last <u>Renner Jr.</u>   |                                  |   |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>13</u> Year <u>19 65</u>   |  |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 12 1965</u> | 9. AGE (In years last birthday)<br>yrs. <u>1</u>  | IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.         | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>none</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>none</u>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY       |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Hagerstown Md.</u> |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u> |
| 13. FATHER'S NAME<br><u>Nevin Duane Renner Sr.</u>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Martha Ebersole</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                                  |   |   | 16. SOCIAL SECURITY NO.   |  |   |  |
| 17. INFORMANT<br><u>Mr. Nevin D. Renner</u>  |                                  |   |   | Address<br><u>Preston Ave. Maugansville Md.</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Anoxia</u><br>7620<br>Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Hyaline membrane disease</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                                  |   |   |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |   |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)   |                                  |   |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m. 19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>65</u> , to <u>12/13</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> 19 <u>65</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.  |                                  |   |   |   |  |   |  |
| 22a. SIGNATURE<br><u>Howard N. Weeks</u>   |                                  |   |   | 22b. DATE SIGNED<br><u>12/14/65</u>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Howard N. Weeks, M.D.</u>   |                                  |   |   | 22d. ADDRESS<br><u>580 Northern Avenue Hagerstown, Maryland</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>Dec. 16-65</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. View Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>Sharpsburg Md.</u>                                     |  |
| 24. FUNERAL DIRECTOR<br><u>Albert L. Leaf Williamsport Md.</u>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br><u>DEC 17 1965</u>   |  |   |  |
|  |                                  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |                                 |  |   |   |                              |  |  |
|--|--|---|---------------------------------|--|---|---|------------------------------|--|--|
| 17078  |  |   |                                 |  | 20460   |   |                              |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY Washington MARYLAND   |  |   |                                 |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Washington |   |                              |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Hagerstown   |  |   | c. LENGTH OF STAY IN 1b<br>Life |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>03 Hagerstown                               |   |                              |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>1617 Marvin Ave.   |  |   |                                 |  | d. STREET ADDRESS<br>1617 Marvin Ave  |   |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) ELWOOD WAYNE RIDER   |  | First Middle Last   |                                 | 4. DATE OF DEATH December 18 1965  |   | Month Day Year  |                              |  |  |
| 5. SEX Male  |  | 6. COLOR OR RACE White  |                                 | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH Feb. 24, 1919                                  |                              | 9. AGE (In years last birthday) 46   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Machanic  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Garage   |                                 | 11. BIRTHPLACE (County & State, or foreign country)<br>Hagerstown, Md.   |   |   | 12. CITIZEN OF WHAT COUNTRY? |  |  |
| 13. FATHER'S NAME<br>Carl Rider  |  |   |                                 | 14. MOTHER'S MAIDEN NAME<br>Flora Evans  |   |   |                              |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>Yes   |  | 16. SOCIAL SECURITY NO.<br>W. W. 2  |                                 | 17. INFORMANT<br>Mrs. Iretta Rider   |   | Address<br>Hagerstown, Md.                                      |                              |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary Occlusion<br>4201 DUE TO Arteriosclerotic heart Disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |   |                                 |  |   |   |                              | INTERVAL BETWEEN ONSET AND DEATH<br>one hr<br>5 yrs                                    |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |                              |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                            |                              |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 7:30 P.M. from the causes and on the date stated above.  |  |   |                                 |  |   |   |                              |  |  |
| 22a. SIGNATURE<br>Donald E. Martin   |  |   |                                 | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                     |   | 22b. DATE SIGNED<br>12/20/65                                    |                              |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>Donald E. Martin M.D.  |  |   |                                 | 22d. ADDRESS<br>418 N. Potomac St  |   |   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>12-22-65   |                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Rose Hill Cemetery   |   | 23d. LOCATION (City, town or county) (State)<br>Hagerstown, Md. |                              |  |  |
| 24. FUNERAL DIRECTOR<br>Scott F. Minnich & Son   |  |   |                                 | ADDRESS<br>Hagerstown, Md.   |   | 25a. REC'D BY REGISTRAR<br>DEC 27 1965                          |                              | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |

STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1910  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1909  
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1910



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND<br>CERTIFICATE OF DEATH   |  |                               |  |  |  |   |  |  |  |
|---|--|-------------------------------|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>2 YEARS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>146 EAST AVENUE</b>   |  |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b><br>d. STREET ADDRESS <b>1 146 EAST AVENUE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>RUSH</b> Middle <b>SHAFFER</b> Last <b>RINEHART</b>   |  |                               |  |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>27</b> Year <b>1965</b>   |   |  |  |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>FEB. 22, 1877</b>   |  | 9. AGE (In years last birthday) <b>88</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED TIME KEEPER</b>  |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>FOOD PROCESSING</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>CHAMBERSBURG, PENNSYLVANIA</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>HARPER RINEHART</b>  |  |                               |  |  | 14. MOTHER'S MAIDEN NAME <b>MARY A. SHAEFFER</b>   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>  |  |                               | 16. SOCIAL SECURITY NO. <b>SPANISH-AMER. 175-03-0122</b> |  | 17. INFORMANT <b>146 EAST AVE. MRS. ALLIA M. RINEHART- HAGERSTOWN, MARYLAND</b>  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Hemorrhage</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE-ARTERIOSCLEROTIC Cerebro-Vascular Disease</b> Yes.<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                               |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>MINUTE</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>19 MAY, 1965</b> , to <b>27 DEC, 1965</b> , that (I) (we) last saw the deceased alive on <b>10 DEC. 1965</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.   |  |                               |  |  |  |   |  |  |  |
| 22a. SIGNATURE <b>[Signature]</b>   |  |                               |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   | 22b. DATE SIGNED <b>12-27-65</b>   |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>WILLIAM NOEL FENDER, M.D.</b>   |  |                               |  |  | 22d. ADDRESS <b>218 N. POTOMAC ST., HAGERSTOWN, MD.</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |                               | 23b. DATE THEREOF <b>DEC. 30, 1965</b>                   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>   |   | 23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b> |  |  |
| 24. FUNERAL DIRECTOR <b>[Signature]</b> ADDRESS <b>HAGERSTOWN, MARYLAND</b>   |  |                               |  |  | 25a. REC'D BY REGISTRAR <b>JAN 3 1966</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                            |  |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17080

## CERTIFICATE OF DEATH

20462

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u><br>c. LENGTH OF STAY IN 1b <u>2 1/2 Mos.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CLEARVIEW NURSING HOME - HAGER MD. RD. 303</u>                    |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u><br>d. STREET ADDRESS <u>Hamilton Hotel</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>RACHEL</u> Middle <u>Ives</u> Last <u>RITCHIE</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>DEC.</u> Day <u>2</u> Year <u>1965</u>   |  |  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>7-31-1881</u>  |  |
| 9. AGE (In years last birthday) <u>84</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Norfolk Co. Va.</u> |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME <u>William P. Ives</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Laura Davis</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) <u>None</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>  </u>   |  |  |  |
| 17. INFORMANT <u>Fortune Odend'hal</u>   |  |   |  | Address <u>2 Roessner Ave Hagerstown, Md.</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma of right colon with gen. metastases</u><br><u>1530</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>  </u><br>(a), stating the underlying cause last. DUE TO (c) <u>  </u> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CACHEXIA and ANEMIA</u>   |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2 Dec 1965</u> , to <u>2 Dec 1965</u> , that (I) (we) last saw the deceased alive on <u>2 December 1965</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.   |  |   |  |   |  |  |  |
| 22a. SIGNATURE <u>Clovis M. Snyder M.D.</u>  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED <u>2 Dec 65</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>CLOVIS M. SNYDER, M.D.</u>   |  |   |  | 22d. ADDRESS <u>106 N. POTOMAC ST. HAGERSTOWN, MD.</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>Dec. 6, 1965</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Park View Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State) <u>Portsmouth, Va.</u>        |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u><br>ADDRESS <u>Funeral Home Inc. Hagerstown, Md.</u>  |  |   |  | 25a. REC'D BY REGISTRAR <u>DEC 7 1965</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



93-68

11-20

DEC 1 1963

*Handwritten signature*



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

17081

20463

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b>      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown, Md. R # 3</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington County Hospital</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Alfred L. Robinson</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Dec, 10. 19 65</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Apr. 12, 1896</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bookkeeper</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Collierstown, Rockridge U.S.A</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |   |
| 13. FATHER'S NAME<br><b>No record</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>No Record</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>223-24-1869</b>   |   |
| 17. INFORMANT<br><b>Mrs. Mary H. Robinson, Hagerstown</b>   |  | Address<br><b>R # 3, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of acetabulum</b><br><b>1969</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>primary site not established</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3-6 mo</b>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)<br>_____ |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>_____   | 20f. (City or town) (County) (State)<br>_____   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9-13, 1959</b> to <b>death</b> , that (I) (we) last saw the deceased alive on <b>12-12-1965</b> , and that death occurred at <b>Hagerstown</b> from the causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><b>Robert F. Keagle</b>   |  | 22b. DATE SIGNED<br><b>12-10-65</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ROBERT F. KEAGLE</b>   |  | 22d. ADDRESS<br><b>Hagerstown, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12/12/65</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crown Hill Cemetery</b>  | 23d. LOCATION (City, town or county) (State)<br><b>Clifton Forge City, Va</b>                         |
| 24. FUNERAL DIRECTOR<br><b>A. K. Coffman Funeral Home, Inc. Hagerstown Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 13 1965</b>   |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ROBERT F. REARD  
Great 7/1/1962

DEC 1 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>  |      |   |   |  |   |   |   |   |  |                    |  |                  |  |        |      |       |      |
|--|------|---|---|--|---|---|---|---|--|--------------------|--|------------------|--|--------|------|-------|------|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u><br>c. LENGTH OF STAY IN ID<br><u>03 Hagerstown</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Martin Manor Nursing Home</u>    |      |   |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>03 Hagerstown</u><br>d. STREET ADDRESS<br><u>25 Laurel</u><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |   |  |                    |  |                  |  |        |      |       |      |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>CATHERINE</u> <u>ODESSA</u> <u>RODGERS</u>  |      |   | <b>4. DATE OF DEATH</b><br><u>Dec.</u> <u>24</u> <u>19 65</u> |  |   |   |   |   |  |                    |  |                  |  |        |      |       |      |
| <b>5. SEX</b><br><u>female</u>   |      | <b>6. COLOR OR RACE</b><br><u>white</u>   |   | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDDED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |   | <b>8. DATE OF BIRTH</b><br><u>March 7, 1884</u>                       |   | <b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> |  | IF UNDER 1 YEAR    |  | IF UNDER 24 HRS. |  | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR  |      | IF UNDER 24 HRS.  |   |  |   |   |   |   |  |                    |  |                  |  |        |      |       |      |
| Months   | Days | Hours   | Min.  |  |   |   |   |   |  |                    |  |                  |  |        |      |       |      |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>   |      |   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Funkstown, Md.</u>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b>                                   |   |   |  |                    |  |                  |  |        |      |       |      |
| <b>13. FATHER'S NAME</b><br><u>David C. Daub</u>   |      |   |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Catherine Bakle</u>   |   |   |   |  |                    |  |                  |  |        |      |       |      |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>no</u>  |      | <b>16. SOCIAL SECURITY NO.</b><br><u>173-03-0286</u>  |   | <b>17. INFORMANT</b><br><u>Harry Daub</u>  |   | <b>Address</b><br><u>Hag., Md.</u>                                    |   |   |  |                    |  |                  |  |        |      |       |      |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u><br>4200<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,<br>DUE TO (b) <u>Arteriosclerosis, cerebral</u><br>DUE TO (c) <u>Fracture, left hip</u> |      |   |   |  |   |   |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>7 months</u><br><u>indefinite</u><br><u>7 months.</u>   |  |                    |  |                  |  |        |      |       |      |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |      |   |   |  |   |   |   | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                    |  |                  |  |        |      |       |      |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |      | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><u>Fell</u>          |   |  |   |   |   |   |  |                    |  |                  |  |        |      |       |      |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>7-11-65</u> p.m.   |      | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><u>home</u>   |   | <b>20f. (City or town)</b><br><u>Hagerstown.</u>                      |   | <b>(County)</b><br>   |  | <b>(State)</b><br> |  |                  |  |        |      |       |      |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7-11-65</u> , <b>19</b> <u>65</u> , <b>to</b> <u>death</u> , <b>19</b> <u>65</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12-10-65</u> , <b>and that death occurred at</b> <u>3:20 A.M.</u> , <b>from the causes and on the date stated above.</b>   |      |   |   |  |   |   |   |   |  |                    |  |                  |  |        |      |       |      |
| <b>22a. SIGNATURE</b><br><u>John C. Morton, M. D.</u>  |      |   |   |  | <b>22b. DATE SIGNED</b><br><u>12-24-65</u>  |   | <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>John C. Morton, M. D.</u> |   | <b>22d. ADDRESS</b><br><u>580 Northern Avenue, Hagerstown,</u> |                    |  |                  |  |        |      |       |      |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>burial</u>  |      | <b>23b. DATE THEREOF</b><br><u>12-27-65</u>   |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Rose Hill Cemetery</u>   |   | <b>23d. LOCATION (City, town or county)</b><br><u>Hagerstown, Md.</u> |   | <b>(State)</b><br>  |  |                    |  |                  |  |        |      |       |      |
| <b>24. FUNERAL DIRECTOR</b><br><u>Scott F. Minnich &amp; Son</u>   |      |   |   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 29 1965</u>  |   | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>           |   |  |                    |  |                  |  |        |      |       |      |

20-581

RETURN OF DEATH

Registration

22 January

David John D. Smith

1-11-88

1-11-88

1-11-88

1-11-88

1-11-88

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

20465

17083

|  |                                     |  |  |   |   |   |   |  |
|--|-------------------------------------|--|--|---|---|---|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>WASHINGTON</b> <span style="float: right;">MARYLAND</span>  |                                     |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>WASHINGTON</b></span> |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>  |                                     |  | c. LENGTH OF STAY IN 1b<br><br>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>104 BROADWAY</b>   |   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>WASHINGTON CO. HOSPITAL</b>   |                                     |  |  | d. STREET ADDRESS<br><b>HAGERSTOWN, MD.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><b>Sadie Catherine Rodgers</b>  |                                     |  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><b>DECEMBER 18 19 65</b>   |   |   |   |  |
| <b>5. SEX</b><br><b>7</b>  | <b>6. COLOR OR RACE</b><br><b>W</b> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>11/29/1879</b>  |   | <b>9. AGE</b> (In years last birthday) yrs. <b>86</b>   |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                     | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>HOME</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>PENNSYLVANIA</b>   |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |   |  |
| <b>13. FATHER'S NAME</b><br><b>DANIEL HELMAN</b>   |                                     |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>MARIA R. SHULL</b>  |   |   |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)<br><b>NO</b>   |                                     | <b>16. SOCIAL SECURITY NO.</b><br><br>   |  | <b>17. INFORMANT</b><br><b>HAGERSTOWN MD.</b><br><b>MR. FRANCIS RODGERS</b>   |   |   |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intermittent Heart Disease &amp; Coronary Artery Disease</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)  |                                     |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Years</b>  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                     |  |  |   |   |   |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                     |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m.  |                                     |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) |   | <b>20f. (City or town) (County) (State)</b> |  |
| <b>21. I certify that I attended the deceased from</b> <b>JAN 16</b> , 19 <b>65</b> , to <b>Dec. 18</b> , 19 <b>65</b> , that I last saw the deceased alive on <b>Dec 17</b> , 19 <b>65</b> , and that death occurred at <b>8:50 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>159 W. WASHINGTON ST. HAGERSTOWN MD.</b> DATE SIGNED <b>12/18/65</b> |                                     |  |  |   |   |   |   |  |
| <b>ACTUAL SIGNATURE</b><br><b>DR. PHILIP J. HIRSHMAN</b>   |                                     |  |  | <b>PHYSICIAN'S NAME (Type)</b>  |   |   |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>BURIAL</b>  |                                     | <b>22b. DATE THEREOF</b><br><b>12/21/65</b>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>RICHLAND CEM.</b>   |   | <b>22d. LOCATION (City, town, or county) (State)</b><br><b>RICHLAND TOWNSHIP PENNA.</b>           |   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>W. T. Harment Hagerstown Md.</b>   |                                     |  |  | <b>24a. REC'D BY REGISTRAR</b><br><b>DEC 23 1965</b>  |   | <b>24b. REGISTRAR'S SIGNATURE</b><br><b>Charles Judge</b>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17084  
CERTIFICATE OF DEATH  
20466

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b<br><b>3 Months</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Western Maryland State Hospital</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>X Rural Hagerstown Rfd. 1</b><br>d. STREET ADDRESS<br><b>1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Clarence Edward Rudy</b><br>First Middle Last  |  |   |  | 4. DATE OF DEATH<br><b>12-25-65</b><br>Month Day Year  |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>11/26/86</b>                                |  |
| 9. AGE (In years last birthday)<br><b>79</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>                |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington Co., Md.</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>George Rudy</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Witmer</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>213-16-0561</b>  |  | 17. INFORMANT<br><b>Mrs. Naomi R. Rudy, Rfd.1 Hagerstown, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b><br>DUE TO (b) <b>163X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>4 mos.</b> |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                               |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12-6, 1965</b> to <b>12-25, 1965</b> , that (I) (we) last saw the deceased alive on <b>12-25, 1965</b> , and that death occurred at <b>2:15 PM</b> from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Arthur Riego</b>  |  |   |  | 22b. DATE SIGNED<br><b>12-25-65</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>ARTHUR RIEGO</b>                |  |
| 22d. ADDRESS<br><b>1500 Penna. Ave., Hagerstown</b>  |  |   |  | 22e. REC'D BY REGISTRAR<br><b>DEC 30 1965</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |  | 23b. DATE THEREOF<br><b>12-28-65</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Beaver Creek Cemetery</b> |  |
| 23d. LOCATION (City, town or county) (State)<br><b>Beaver Creek, Md.</b>   |  |   |  | 23e. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>  |  |   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |  |  |   |  |  |   |
|--|--|--|---|--|--|---|--|--|---|
| CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>----</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D O A WASHINGTON COUNTY HOSPITAL</b>  |  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>d. STREET ADDRESS <b>HAMILTON HOTEL</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MAMIE</b> Middle <b>LOUISE</b> Last <b>SMITH</b>   |  |  |   |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>26</b> , Year <b>1965</b>   |   |  |  |   |
| 5. SEX <b>FEMALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>          |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>NOV. 6, 1881</b>   |  | 9. AGE (in years last birthday) <b>84</b> yrs. IF UNDER 1 YEAR: Months <b>----</b> Days <b>----</b> Hours <b>----</b> Min. <b>----</b> IF UNDER 24 HRS. Months <b>----</b> Days <b>----</b> Hours <b>----</b> Min. <b>----</b> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>   |  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13. FATHER'S NAME <b>SCOTT ZEIGLER</b>   |  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>KATE MIDDLEKAUFF</b>   |   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>----</b>  |  |  |   |  | 16. SOCIAL SECURITY NO. <b>NONE</b>  |   | 17. INFORMANT Address <b>MRS. FRANK BEAVER- CENTERVILLE, MARYLAND</b>        |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Found dead on street -</b><br><b>443X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b><br>(c) <b>Diabetes mellitus</b> |  |  |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>15 years -</b><br><b>14 years</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |   |  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)   |  |   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7-5, 1965</b> , to <b>12/26, 1965</b> , that (I) (we) last saw the deceased alive on <b>10/19 1965</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.  |  |  |   |  |  |   |  |  |   |
| 22a. SIGNATURE <b>John H. Hornbaker</b>  |  |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   | 22b. DATE SIGNED <b>12-27-65</b>   |  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>JOHN H. HORNBAKER, M.D.</b>  |  |  |   |  | 22d. ADDRESS <b>154 W. WASHINGTON ST., HAGERSTOWN, MD.</b>   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE THEREOF <b>DEC. 29, 1965</b> |   | 23c. NAME OF CEMETERY OR CREMATORY <b>CORAOPOLIS CEMETERY</b>  |  |   | 23d. LOCATION (City, town or county) (State) <b>CORAOPOLIS, PENNSYLVANIA</b> |  |   |
| 24. FUNERAL DIRECTOR <b>Charles M. Housee</b>  |  |  |   |  | ADDRESS <b>HAGERSTOWN, MARYLAND</b>  |   | 25a. REC'D BY REGISTRAR <b>JAN 3 1966</b>                                    |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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|   |                                  |   |   |   |   |   |   |
|---|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sharpsburg</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>Lifetime</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sharpsburg</u>   |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>200 E Main St.</u>   |                                  |   |   | d. STREET ADDRESS<br><u>Mc Comas Ave</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>Virginia</u> Last <u>Wilson Smith</u>  |                                  |   |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>10</u> Year <u>1965</u>  |   |   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Jan. 20 1879</u> |   | 9. AGE (In years last birthday)<br><u>86</u> yrs. | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Sharpsburg Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |   |
| 13. FATHER'S NAME<br><u>Joshua Wilson</u>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary Virginia Cronise</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |   | 17. INFORMANT<br>Address <u>  </u>  |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u><br><u>4201</u> DUE TO <u>Generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> |                                  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3-4 weeks</u><br><u>years -</u>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>63</u> , to <u>Dec 10</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 10</u> 19 <u>65</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.  |                                  |   |   |   |   |   |   |
| 22a. SIGNATURE<br><u>JOSEPH SECONDARI</u>   |                                  |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |   | 22b. DATE SIGNED<br><u>12.10.65</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Joseph Secondari</u>   |                                  |   |   | 22d. ADDRESS<br><u>Boonsboro, Md.</u>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>Dec. 12-65</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. View Cemetery</u>  |   | 23d. LOCATION (City, town or county) (State)<br><u>Sharpsburg Md.</u>                             |   |
| 24. FUNERAL DIRECTOR<br><u>Albert L. Leaf</u>   |                                  |   |   | ADDRESS<br><u>Williamsport Md.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>DEC 13 1965</u>   |   |
|   |                                  |   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                   |                   |  |   |  |  |                                      |  |
|---|--|-----------------------------------|-------------------|--|---|--|--|--------------------------------------|--|
| 17087   |  |                                   |                   |  | 20469   |  |  |                                      |  |
| 1. PLACE OF DEATH   |  |                                   |                   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) |  |  |                                      |  |
| a. COUNTY   |  | Washington                        |                   |  | a. STATE  |  | Maryland                                     |                                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | Hagerstown                        |                   |  | b. COUNTY   |  | Washington                                   |                                      |  |
| c. LENGTH OF STAY IN 1b   |  | 21 days                           |                   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      |  | Rural Hagerstown RFD #2                      |                                      |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |                                   |                   |  | d. STREET ADDRESS   |  |  |                                      |  |
| Washington County Hospital  |  |                                   |                   |  | Huyetts Cross Roads   |  |  |                                      |  |
| e. IS RESIDENCE ON A FARM?  |  |                                   |                   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |  |                                      |  |
| 3. NAME OF DECEASED (Type or print)   |  |                                   |                   |  | 4. DATE OF DEATH  |  |  |                                      |  |
| First   |  | Middle                            |                   | Last   |   | Month  |  | Day Year                             |  |
| Anna  |  | Bell                              |                   | Snapp  |   | Dec.   |  | 26 19 65                             |  |
| 5. SEX  |  | 6. COLOR OR RACE                  |                   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                   |   | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday)      |  |
| Female  |  | White                             |                   | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                |   | Nov. 11 1885   |  | 80 yrs.                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY |                   | 11. BIRTHPLACE (County & State, or foreign country)  |   | 12. CITIZEN OF WHAT COUNTRY?   |  | IF UNDER 1 YEAR                      |  |
| Housewife   |  | Home                              |                   | Pa.  |   | U. S. A.   |  | Months Days Hours Min.               |  |
| 13. FATHER'S NAME   |  |                                   |                   |  | 14. MOTHER'S MAIDEN NAME  |  |  |                                      |  |
| Issac N. Milliken   |  |                                   |                   |  | Bertha Young  |  |  |                                      |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |                                   |                   |  | 16. SOCIAL SECURITY NO.   |  |  |                                      |  |
| No  |  |                                   |                   |  | none  |  |  |                                      |  |
| 17. INFORMANT   |  |                                   |                   |  | Address   |  |  |                                      |  |
| Charles M Snapp   |  |                                   |                   |  | Huyetts Cross Roads Hagerstown Md RFD #2  |  |  |                                      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |                                   |                   |  |   |  |  |                                      | INTERVAL BETWEEN ONSET AND DEATH   |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  |                                   |                   |  |   |  |  |                                      | 1 year or more   |
| 1750 Ovarian carcinoma with   |  |                                   |                   |  |   |  |  |                                      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                                   |                   |  |   |  |  |                                      |  |
| DUE TO (b) abdominal abscesses and abdominal  |  |                                   |                   |  |   |  |  |                                      |  |
| DUE TO (c) fistulae   |  |                                   |                   |  |   |  |  |                                      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                   |                   |  |   |  |  |                                      | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| malnutrition  |  |                                   |                   |  |   |  |  |                                      |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                   |                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |  |  |                                      |  |
| 20c. TIME OF INJURY Month, Day, Year  |  |                                   |                   | 20d. INJURY OCCURRED   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State) |  |
| Hour a.m. p.m. 19   |  |                                   |                   | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |   |  |  |                                      |  |
| 21. I certify that (I) (this hospital) attended the deceased from Dec, 1964, to death, 19, that (I) (we) last saw the deceased alive on Dec 26 19 65, and that death occurred at M, from the causes and on the date stated above. |  |                                   |                   |  |   |  |  |                                      |  |
| 22a. SIGNATURE  |  |                                   |                   |  |   |  |  |                                      | 22b. DATE SIGNED   |
| John C. Stauffer  |  |                                   |                   |  |   |  |  |                                      | Dec. 27, 1965  |
| 22c. PHYSICIAN'S NAME (Type)  |  |                                   |                   |  |   |  |  |                                      | 22d. ADDRESS   |
| John C. Stauffer M.D.   |  |                                   |                   |  |   |  |  |                                      | Hagerstown, Md.  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                                   | 23b. DATE THEREOF |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town or county) (State) |                                      |  |
| Burial  |  |                                   | Dec. 29-65        |  | Rest Haven Cemetery   |  | Hagerstown Maryland                          |                                      |  |
| 24. FUNERAL DIRECTOR  |  |                                   |                   |  | 25a. REC'D BY REGISTRAR   |  |  |                                      |  |
| Albert L. Leaf Williamsport Md.   |  |                                   |                   |  | DEC 29 1965   |  |  |                                      |  |
|   |  |                                   |                   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                                      |  |
|   |  |                                   |                   |  | Charles Judge   |  |  |                                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |   |   |   |   |   |  |  |
|---|--|---|---|---|---|---|---|--|--|
| CERTIFICATE OF DEATH  |  |   |   |   |   |   |   |  |  |
| 20470   |  |   |   |   |   |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Washington</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u><br>c. LENGTH OF STAY IN 1b<br><u>1 Day</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Martin Manor Rest Home</u>                                |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE<br><u>Maryland</u><br>b. COUNTY<br><u>Washington</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Boonsboro</u><br>d. STREET ADDRESS<br><u>Rfd. 1</u><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Mary K. Snelling</u>  |  |   | 4. DATE OF DEATH<br><u>December 11, 19 65</u> |   |   |   |   |  |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>June 6, 1890</u>                                 |   | 9. AGE (In years last birthday)<br><u>75</u> yrs.                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Cumberland, Md.</u>   |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u> |  |  |
| 13. FATHER'S NAME<br><u>Nathan Stallings</u>  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Anna Twigg</u>   |   |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No.</u>   |  |   |   | 16. SOCIAL SECURITY NO.<br><u>None</u>  |   | 17. INFORMANT<br><u>Mr. Boyd H. Snelling Rfd. 1, Boonsbor Md.</u>       |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular Disease</u><br><u>4431</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Pylorospasm</u><br>(c) <u>Arterio-sclerosis</u> |  |   |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sept 15 - 1965</u><br><u>June 15 - 1965</u>     |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                    |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15 - 1965</u> to <u>Dec 11, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 10, 1965</u> , and that death occurred at <u>8:40 A.M.</u> from the causes and on the date stated above.   |  |   |   |   |   |   |   |  |  |
| 22a. SIGNATURE<br><u>Sidney M. Weinstein</u>  |  |   |   | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |   | 22b. DATE SIGNED<br><u>12-11-65</u>                                     |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>SIDNEY WEINSTEIN</u>   |  |   |   | 22d. ADDRESS<br><u>FUNKSTOWN MD</u>   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>12-14-65</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Manor Cemetery</u>   |   | 23d. LOCATION (City, town or county) (State)<br><u>Tilghmanton, Md.</u> |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md</u>  |  |   |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br><u>DEC 17 1965</u>                           |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                     |  |

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(c)  $\alpha \in \text{int}(A)$ ,  $p \in \partial A$ . Then  $\nabla f(p) = \lambda \nabla g(p)$ ,  $\lambda \geq 0$ .

FOR STATE  
HEALTH DEPT.

17089

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20471

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>W. Va.</b> b. COUNTY <b>Morgan</b>                           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  | c. LENGTH OF STAY IN lb<br><b>10 Days</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington County Hospital</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <b>Richard Porter Speilman</b>  |  | 4. DATE OF DEATH <b>December 10, 19 65</b>  |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>Mar. 1, 1938</b>  |
| 9. AGE (In years last birthday) <b>27 yrs.</b>  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>9</b> Days <b>9</b> Hours <b>9</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>State Park</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Morgan County, W. Va.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Ardell W. Spielman</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Eunice Porter</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>233-60-3126</b>  |   |
| 17. INFORMANT <b>Patricia C. Spielman</b> Address <b>Berkeley Spgs. W. Va.</b>  |  | 18. MOTHER'S MAIDEN NAME <b>Mrs Patricia C. Spielman</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fibropurulent Peritonitis</b><br>8163 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Perforation Jejunum (contusion of jejunum)</b><br>DUE TO<br>(c)  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Comminuted fracture of lt. femur - lobular pneumonia, bilateral</b>  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Head on collision with pick up truck at road intersection.</b> |   |
| 20c. TIME OF INJURY Month, Day, Year<br><b>3:10 p.m. 12-1- 1965</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>R# 522 South Berkley Springs, W. Va.</b>   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>  |  | 22. DATE SIGNED <b>12-11-65</b>   |   |
| EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>  |  | Address <b>245 W. Washington S., Hagerstown, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>12/13/1965</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>   | 23d. LOCATION (City, town or county) (State)<br><b>Berkeley Springs, W. Va.</b>                   |
| 24. FUNERAL DIRECTOR <b>Johnson Funeral Homes, Berkeley Spgs. W. Va.</b>  |  | 25. REC'D BY REGISTRAR <b>DEC 15 1965</b> REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



50171

1403

Washington County Hospital  
10 Days  
Berkeley, California  
Kovacs, J.

State Park  
Berkeley, California  
Kovacs, J.  
Berkeley, California  
Kovacs, J.

Washington County Hospital  
Berkeley, California  
Kovacs, J.  
Berkeley, California  
Kovacs, J.

12/13/55  
Berkeley, California  
Kovacs, J.  
Berkeley, California  
Kovacs, J.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                             |  |   |  |  |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                             |  |   |  |  |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |                             |  |   |  |  |  |   |  |   |  |
| 20472   |  |                             |  |   |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY Washington MARYLAND  |  |                             |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Md. b. COUNTY Washington           |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hagerstown  |  |                             |  | c. LENGTH OF STAY IN 1b<br>18 Days  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hagerstown                                       |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Washington County Hospital  |  |                             |  |   |  | d. STREET ADDRESS<br>1008 Fairview Rd.   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Heila Mae Stine   |  |                             | 4. DATE OF DEATH<br>Month Day Year<br>Dec. 30 1965 |   |  |  |  |   |  |   |  |
| 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>White   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>2/26/1889  |  | 9. AGE (In years last birthday)<br>76 yrs.                                    |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>House Duties   |  |                             |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Worleytown, Pa.   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13. FATHER'S NAME<br>Mordecai Hoover  |  |                             |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Emma Rebuck  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  |                             |  | 16. SOCIAL SECURITY NO.<br>219-12-1629  |  | 17. INFORMANT<br>Mr. Wesley E. Stine, Hagerstown, Md.  |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |                             |  |   |  |  |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Ventricular Fibrillation<br>4201 DUE TO Myocardial infarction<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Coronary artery disease<br>(c) INTERVAL BETWEEN ONSET AND DEATH<br>12/2/65 |  |                             |  |   |  |  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>Hypertension - Deafness mellitus   |  |                             |  |   |  |  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                             |  |   |  |  |  |   |  |   |  |
| MEDICAL CERTIFICATION   |  |                             |  |   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                             |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  |                             |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from 1948, 19, to death 19, that (I) (we) last saw the deceased alive on 12-20-65 19, and that death occurred at 5:30 P.M. from the causes and on the date stated above.   |  |                             |  |   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br>Robert F. Keadle  |  |                             |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br>1-4-65  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>Robert F. Keadle, M.D.  |  |                             |  |   |  | 22d. ADDRESS<br>Hagerstown Md  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE THEREOF<br>1/3/66 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Hill  |  |  |  | 23d. LOCATION (City, town or county) (State)<br>Waynesboro, Franklin Co., Pa. |  |   |  |
| 24. FUNERAL DIRECTOR<br>Walter Y. Grove   |  |                             |  | ADDRESS<br>Waynesboro Pa.   |  |  |  | 25a. REC'D BY REGISTRAR<br>JAN 7 1966   |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge  |  |

STATION

STATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> <p>1</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">20473</p> </div>  |  |  |   |  |   |   |  |  |  |   |  |
|--|--|--|---|--|---|---|--|--|--|---|--|
| <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Washington</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u></p> <p>c. LENGTH OF STAY IN 1b <u>6 months</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Friendship Manor</u></p>  |  |  |   |  | <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> <u>75x-3</u></p> <p>d. STREET ADDRESS <u>226 Paek St.</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></p> |   |  |  |  |   |  |
| <p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>S.</u> Middle <u>Ella</u> Last <u>Stoner</u></p>  |  |  | <p>4. DATE OF DEATH</p> <p>Month <u>12</u> Day <u>1</u> Year <u>1965</u></p>                                      |  | <p>5. SEX <u>Female</u></p>   |   |  | <p>6. COLOR OR RACE <u>white</u></p>                   |  | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> |  |
| <p>8. DATE OF BIRTH <u>4/12/1887</u></p>   |  |  | <p>9. AGE (In years last birthday) <u>78</u> yrs.</p>   |  |   | <p>IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u></p>                                |  | <p>IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u></p> |  |   |  |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u></p>   |  |  |   | <p>10b. KIND OF BUSINESS OR INDUSTRY</p> |   | <p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>Rouzeville, Pa.</u></p> |  | <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>      |  |   |  |
| <p>13. FATHER'S NAME <u>Issac Smith</u></p>  |  |  |   |  | <p>14. MOTHER'S MAIDEN NAME <u>Margaret Hartman</u></p>   |   |  |  |  |   |  |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)</p>   |  |  | <p>16. SOCIAL SECURITY NO. <u>173-03-3575D</u></p>  |  | <p>17. INFORMANT Address <u>Hagerstown, Md.</u><br/><u>Elder S. Stoner 2063 Virginia Ave.</u></p>   |   |  |  |  |   |  |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u></p> <p>1992 DUE TO (b) <u>Generalized Carcinomatosis</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>  </u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u></p> |  |  |   |  |   |   |  |  | <p>INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u></p> <p><u>6 yrs.</u></p> |   |  |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>  |  |  | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>               |  |   |   |  |  |  |   |  |
| <p>20c. TIME OF INJURY Month, Day, Year<br/>Hour a.m. <u>  </u> p.m. <u>19</u></p>   |  |  | <p>20d. INJURY OCCURRED<br/>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> |  | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>   |   | <p>20f. (City or town) (County) (State)</p>                                    |  |  |   |  |
| <p>21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u>, 19<u>65</u>, to <u>Dec 1</u>, 19<u>65</u>, that (I) (we) last saw the deceased alive on <u>12-1</u>, 19<u>65</u>, and that death occurred at <u>8:00</u> P. M., from the causes and on the date stated above.</p>   |  |  |   |  |   |   |  |  |  |   |  |
| <p>22a. SIGNATURE <u>Robert P. Connor</u></p>  |  |  |   |  | <p>22b. DATE SIGNED <u>12-2-65</u></p>  |   | <p>22c. PHYSICIAN'S NAME (Type) <u>Robert P. Connor</u></p>                    |  |  |   |  |
| <p>22d. ADDRESS <u>137 W. Washington</u><br/><u>Hagerstown, Md.</u></p>  |  |  |   |  | <p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>  |   |  |  |  |   |  |
| <p>23b. DATE THEREOF <u>12/4/1965</u></p>  |  |  | <p>23c. NAME OF CEMETERY OR CREMATORY <u>Harbaugh</u></p>   |  |   |   | <p>23d. LOCATION (City, town or county) (State) <u>Franklin Co. Penna.</u></p> |  |  |   |  |
| <p>24. FUNERAL DIRECTOR <u>Walter J. Lyne</u></p>  |  |  |   |  | <p>25a. REC'D BY REGISTRAR <u>DEC 6 1965</u></p>  |   | <p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>                         |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
| 17092 20474   |  |   |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> <u>MARYLAND</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u><br>c. LENGTH OF STAY IN 1b <u>27 Yrs.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>409 Suman Ave</u>  |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u><br>d. STREET ADDRESS <u>409 Suman Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Mary Elizabeth Strother</u><br>First Middle Last  |  |   |  |   | 4. DATE OF DEATH<br>Month Day Year <u>Dec 6 1965</u>   |  |  |   |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>Colored</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>April 17 1926</u>                              |  | 9. AGE (In years last birthday) <u>39</u>                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Funkstown Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                            |  |   |  |
| 13. FATHER'S NAME <u>Charles Clark</u>  |  |   |  |   | 14. MOTHER'S MAIDEN NAME <u>Rosena Caroll</u>  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  | 16. SOCIAL SECURITY NO. <u>none</u>   |  | 17. INFORMANT Address <u>Robert H. Strother 409 Suman Ave.</u>  |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (possible ruptured cerebral aneurysm)</u><br>443X<br>Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive cardiovascular disease</u><br>(e), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 1/2 hours</u><br><u>9 months</u> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                               |  |   |  |
| 21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>March 1965</u> , to <u>Dec. 6 1965</u> , that (I) ( <u>was</u> ) last saw the deceased alive on <u>Nov. 30 1965</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.   |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE <u>William T. Layman</u>   |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED <u>12/7/65</u>                                    |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>   |  |   |  | 22d. ADDRESS <u>100 Professional Arts Bldg. Hagerstown, Maryland</u>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>Dec 9 1965</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u> |  |   |  |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr</u>   |  |   |  | ADDRESS <u>Hagerstown md</u>  |  | 25a. REC'D BY REGISTRAR <u>DEC 9 1965</u>                          |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                           |  |

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TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text block containing several lines of typed information, possibly a memorandum or report header.]

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*[Handwritten signature]*

100134  
[Illegible text block containing several lines of typed information, possibly a memorandum or report footer.]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |  |  |  |  |  |   |   |
|--|--|-------------------------------|--|--|--|--|--|---|---|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |  |  |  |  |  |   |   |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                               |  |  |  |  |  |   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>two days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>  |  |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b><br>d. STREET ADDRESS <b>408 Center Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CARL</b> Middle <b>WILHELM</b> Last <b>THORESEN</b>  |  |                               |  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>1</b> Year <b>1965</b>  |  |  |   |   |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH<br><b>May 21, 1925</b>  |  | 9. AGE (In years last birthday) <b>40</b> yrs.<br>IF UNDER 1 YEAR: Months <b>1</b> Days <b>1</b><br>IF UNDER 24 HRS.: Hours <b>1</b> Min. <b>15</b> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fire Dept. Ft. Detrick, Md.</b>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>                 |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |
| 13. FATHER'S NAME <b>Wilhelm Thoresen</b>  |  |                               |  |  | 14. MOTHER'S MAIDEN NAME <b>Helga Anderson</b>   |  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>   |  |                               | 16. SOCIAL SECURITY NO. <b>W.W. 11 336-18-8227</b> |  | 17. INFORMANT <b>Mrs. Helen B. Thoresen</b> Address <b>408 Center St. Fred. Md.</b>  |  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>983x ① Massive Hemorrhage Lower Esophagus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>② Infection Pons and Lower Midbrain</b><br>DUE TO (b) <b>Infection</b><br>DUE TO (c) <b>Midbrain</b>  |  |                               |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>2-4 hrs.</b><br><b>Indef.</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |                               |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Injury to head - Possibly due to assault in Frederick, Md.</b> |  |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year <b>12<sup>th</sup> a.m. 11/14 1965</b>  |  |                               |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> |  | 20f. (City or town) <b>Frederick</b> (County) <b>Fred</b> (State) <b>Md</b>   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |                               |  |  |  |  |  |   |   |
| ACTUAL SIGNATURE <b>Edward W. Dittus III</b>   |  |                               |  |  | 22. DATE SIGNED <b>12/1/65</b>   |  |  |   |   |
| EXAMINER'S NAME (Type) <b>Edward W. Dittus III, MD, 212 W. Washington St., Hagerstown, Md.</b>   |  |                               |  |  | 23. LOCATION (City, town or county) (State) <b>Ft. Myer, Virginia</b>  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                               | 23b. DATE THEREOF <b>12-3-1965</b>                 |  | 23c. NAME OF CEMETERY OR CREMATOR <b>Arlington National Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State) <b>Ft. Myer, Virginia</b> |   |   |
| 24. FUNERAL DIRECTOR <b>Robert E. Dailey and Son</b>   |  |                               |  |  | ADDRESS <b>Frederick, Maryland</b>   |  | 25a. REC'D BY REGISTRAR <b>DEC 3 1965</b>                              |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |

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TO THE HONORABLE THE SECRETARY OF DEFENSE  
WASHINGTON, D.C. 20301

SUBJECT: [Illegible]

DATE: [Illegible]

FROM: [Illegible]

[The following text is extremely faint and largely illegible, appearing to be a memorandum or letter. It contains several paragraphs of text, some of which may be headings or subheadings, but the specific content cannot be accurately transcribed.]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20476

|   |   |  |   |   |  |  |  |
|---|---|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Washington</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Boonsboro</u><br>c. LENGTH OF STAY IN 1b<br><u>Life</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Rfd. 2</u>  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE<br><u>Maryland</u><br>b. COUNTY<br><u>Washington</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Boonsboro</u><br>d. STREET ADDRESS<br><u>Rfd. 2</u><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Veniah</u> Middle <u>E.</u> Last <u>Summers</u>   |   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>6</u> Year <u>1965</u> |   |  |  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>September 18, 1902</u>                           | 9. AGE (In years last birthday)<br><u>63</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>2</u> Days <u>18</u> Hours <u></u> Min. <u></u> |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Butcher &amp; Bus Operator</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Food &amp; Trans.</u>  | 11. BIRTHPLACE (State or foreign country)<br><u>Boonsboro, Md.</u>      |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                              |  |  |
| 13. FATHER'S NAME<br><u>Ezra D. Summers</u>   |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Gertie V. Houpt</u>                      |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No.</u>   |   | 16. SOCIAL SECURITY NO.<br><u>218-24-2004</u>  | 17. INFORMANT<br><u>Mrs. Pauline C. Summers Boonsboro Rfd. 2, Md.</u>   |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u><br>(c) <u>Heart Failure</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 yrs</u>                             |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)   | (County)  | (State)  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                   |   |  |   |   |  |  |  |
| ACTUAL SIGNATURE<br><u>J. E. W. White</u><br>EXAMINER'S NAME (Type)<br><u>J. E. W. White</u>  |   | M.O.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |   | 22. DATE SIGNED<br><u>12/6/65</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>12-8-65</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Boonsboro Cemetery</u>  | 23d. LOCATION (City, town or county) (State)<br><u>Boonsboro, Md.</u>   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>John H. Bast, Jr. 112 N. Main St., Boonsboro, Md.</u>   |   |  | 25a. REC'D BY REGISTRAR<br><u>DEC 8 1965</u>                            | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |

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NATIONAL BUREAU OF INVESTIGATION

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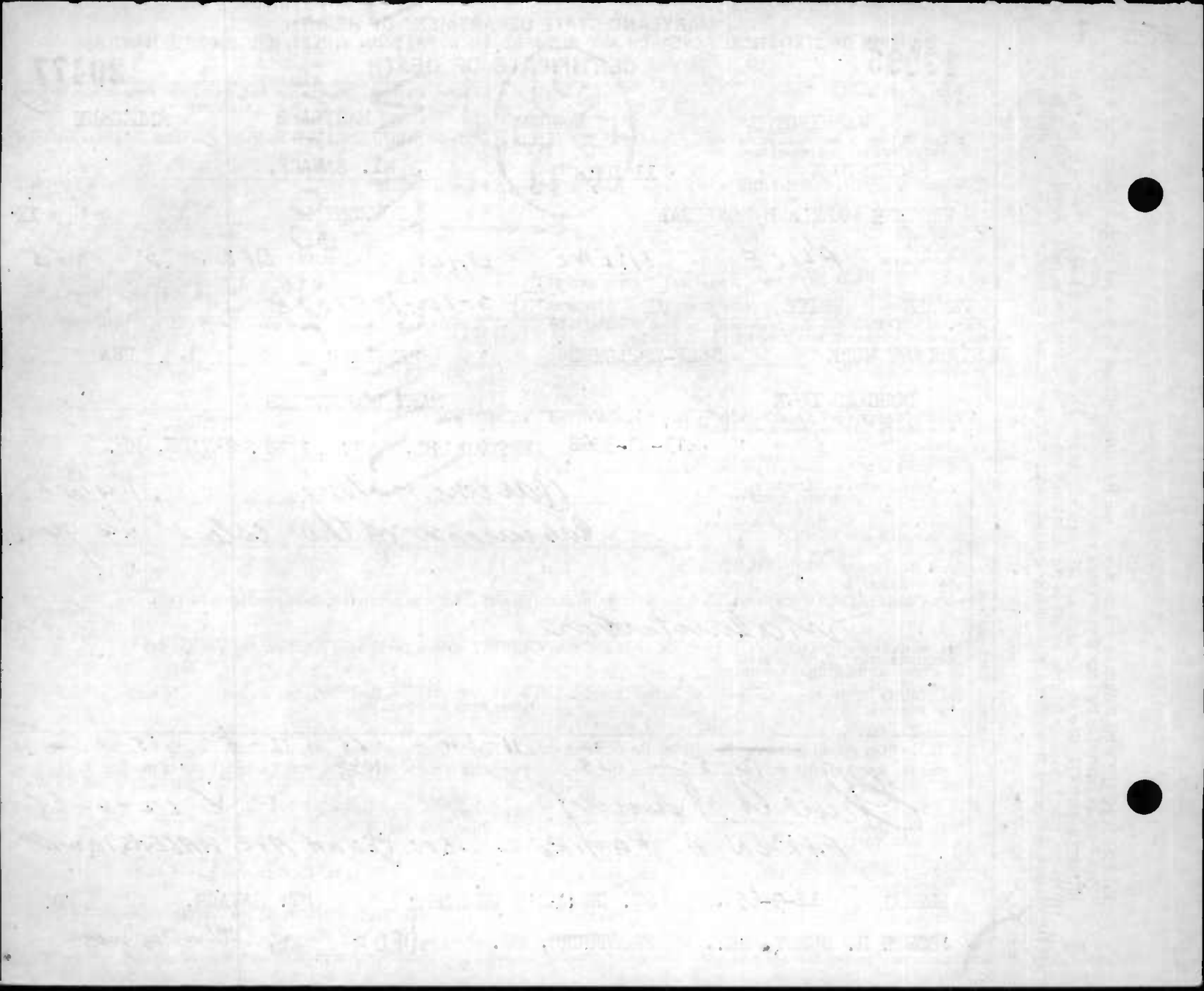
DEC 8 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND<br><b>CERTIFICATE OF DEATH</b>   |  |                                     |   |  |   |  |  |   |  |  |
|--|--|-------------------------------------|---|--|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> MARYLAND  |  |                                     |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |  |  |   |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>  |  |                                     |   |  | c. LENGTH OF STAY IN 1b<br><b>11 DAYS</b>   |  |  |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>WESTERN MARYLAND HOSPITAL</b>   |  |                                     |   |  | d. STREET ADDRESS<br><b>FOUNDRY ROW</b>   |  |  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>ALICE</b> First <b>IRENE</b> Middle <b>UHL</b> Last  |  |                                     |   |  | 4. DATE OF DEATH<br><b>DEC 5 1965</b>   |  |  |   |  |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>    |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>5-10-1887</b>                                   |  | 9. AGE (In years last birthday)<br><b>78</b> yrs. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RESTAURANT WORK</b>  |  |                                     |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMPLOYED</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |
| 13. FATHER'S NAME<br><b>DOUGLAS LOVE</b>   |  |                                     |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY HOSTETTLER</b>  |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>(Yes, no, or unknown)</b>  |  |                                     |   |  | 16. SOCIAL SECURITY NO.<br><b>213-22-3568</b>   |  | 17. INFORMANT<br><b>REFORD UHL,</b>                                    |   | Address<br><b>MT. SAVAGE, MD.</b>          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1538</b> DUE TO <b>Carcinoma of the colon</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 year</b><br>DUE TO (c) <b>4 years</b> |  |                                     |   |  |   |  |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Malnutrition</b>  |  |                                     |   |  |   |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                     |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.   |  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                   |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11-24-1965</b> , to <b>12-5-1965</b> , that (I) (we) last saw the deceased alive on <b>12-5-1965</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.   |  |                                     |   |  |   |  |  |   |  |  |
| 22a. SIGNATURE<br><b>Ehren A. Ramirez</b>  |  |                                     |   |  | 22b. DATE SIGNED<br><b>12-6-65</b>  |  |  |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>EAREN A. RAMIREZ</b>  |  |                                     |   |  | 22d. ADDRESS<br><b>1500 PENNA AVE HAGERSTOWN</b>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>12-9-65</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. GEORGE'S CEMETERY</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>MT. SAVAGE, MD.</b> |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>JOSEPH R. DURST, SR.,</b>   |  |                                     |   |  | ADDRESS<br><b>FROSTBURG, MD.</b>  |  |  |   |  |  |
| 25a. REC'D BY REGISTRAR<br><b>DEC 9 1965</b>   |  |                                     |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |  |  |   |  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |                  |   |   |               |   |                  |   |                  |             |
|--|------------------|---|---|---------------|---|------------------|---|------------------|-------------|
| 17096  |                  |   |   |               | 20478   |                  |   |                  |             |
| 1. PLACE OF DEATH  |                  |   |   |               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                       |                  |   |                  |             |
| a. COUNTY<br><b>Washington</b>   |                  |   |   |               | b. COUNTY<br><b>Mont.</b>   |                  |   |                  |             |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                  |   |   |               | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rural Germantown</b> |                  |   |                  |             |
| c. LENGTH OF STAY IN 1b<br><b>30 days</b>  |                  |   |   |               | d. STREET ADDRESS<br><b>15X-2</b>   |                  |   |                  |             |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Western Md. State Hospital</b>  |                  |   |   |               | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                  |   |                  |             |
| 3. NAME OF DECEASED (Type or print)  |                  |   | First   | Middle        | Last  | 4. DATE OF DEATH | Month   | Day              | Year        |
|  |                  |   | <b>JAMES</b>  | <b>HALLER</b> | <b>WATKINS</b>  |                  | <b>12</b>   | <b>20</b>        | <b>1965</b> |
| 5. SEX   | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH  |               | 9. AGE (In years last birthday)   | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS. |             |
| <b>M</b>   | <b>W</b>         | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>12-2-88</b>  |               | <b>77</b> yrs.  | Months           | Days  | Hours            | Min.        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |               | 11. BIRTHPLACE (County & State, or foreign country)   |                  | 12. CITIZEN OF WHAT COUNTRY?  |                  |             |
| <b>Barber</b>  |                  |   | <b>Barber</b>   |               | <b>Cedar Grove, Md.</b>   |                  | <b>USA</b>  |                  |             |
| 13. FATHER'S NAME<br><b>James Willard Watkins</b>  |                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Charlotte Williams</b>   |               |   |                  |   |                  |             |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                  |   | 16. SOCIAL SECURITY NO.   |               | 17. INFORMANT   |                  | Address   |                  |             |
| <b>no</b>  |                  |   | <b>None</b>   |               | <b>Mrs. Harry E. Hahn</b>   |                  | <b>Mt. Airy, Md.</b>  |                  |             |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA</b><br><b>4500</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETIS MELLITUS</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> |                  |   |   |               |   |                  |   |                  |             |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |               |   |                  |   |                  |             |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |               | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                      |                  | 20f. (City or town) (County) (State)                                    |                  |             |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10-21-1965</b> to <b>12-20-1965</b> , that (I) (we) last saw the deceased alive on <b>12-20-1965</b> , and that death occurred at <b>5:45 P</b> from the causes and on the date stated above.   |                  |   |   |               |   |                  |   |                  |             |
| 22a. SIGNATURE<br><b>Eugen A. Ramirez</b>  |                  |   |   |               | 22b. DATE SIGNED<br><b>12-20-65</b>   |                  |   |                  |             |
| 22c. PHYSICIAN'S NAME (Type)<br><b>EUGEN A. RAMIREZ, MD</b>  |                  |   |   |               | 22d. ADDRESS<br><b>1500 PENN. AVE., HAGERSTOWN, MD.</b>   |                  |   |                  |             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                  |   | 23b. DATE THEREOF<br><b>12-22-65</b>  |               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Salem</b>  |                  | 23d. LOCATION (City, town or county) (State)<br><b>Cedar Grove, Md.</b> |                  |             |
| 24. FUNERAL DIRECTOR<br><b>Francis H. Barber Laytonsville, Md.</b>   |                  |   |   |               | 25a. REC'D BY REGISTRAR<br><b>DEC 22 1965</b>   |                  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                    |                  |             |

Mont.

Id.

Washington

Georgetown

Rural

30 days

Georgetown

Western Md. State Hospital

USA

Cedar Grove, Md.

Barber

Barber

Charlotte Williams

James William Watkins

Mr. Harry E. Hahn  
Mt. Airy, Md.

None

no

Cedar Grove, Md.

Salem

12-22-62

Rural

Francis H. Barber  
Hagerstown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

17097

20479

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b>      |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown R # 5</b>   |  | c. LENGTH OF STAY IN 1b<br><b>4 Yrs</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Hagerstown R # 5</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Leitersburg</b>  |  |   |  | d. STREET ADDRESS<br><b>Leitersburg</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIAM</b> Middle <b>EDWARD</b> Last <b>WELCH</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Dec</b> Day <b>3</b> Year <b>1965</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 3 1924</b>   |  |
| 9. AGE (In years last birthday)<br><b>41</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.                                  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Security Wash Co Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Shoe Repair</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Goodwill</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Security Wash Co Md.</b>                |  |
| 13. FATHER'S NAME<br><b>Samuel K. Welch</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Williams</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>219-30-2953</b>   |  | 17. INFORMANT<br>Address<br><b>Mrs Bertha M. Clark Hagerstown R #5</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>416X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Rheumatic Heart Disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs.</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-1</b> , 19 <b>63</b> , to <b>12-3</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>11-3</b> , 19 <b>65</b> , and that death occurred at <b>2:30</b> AM, from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Charles E. Hens</b>  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED<br><b>12-4-65</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles E. Hens</b>  |  |   |  | 22d. ADDRESS<br><b>Smithsburg, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>12-6-65</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Hagerstown Wash Co Md</b>                      |  |
| 24. FUNERAL DIRECTOR<br><b>Andrew K. Coffman Funeral Home Inc</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 7 1965</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| 17098   |  |  |  |  | Item #14 Film #9312 12/29/65 DC   |  |  |  |  | 20480   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE         |  |  |  |  | b. COUNTY   |  |  |  |  |
| Washington  |  |  |  |  | MARYLAND  |  |  |  |  | WASHINGTON  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Williamsport  |  |  |  |  | c. LENGTH OF STAY IN 1b<br>Aug 24, 1964 - 12/25/65  |  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>RURAL HAGERSTOWN  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Williamsport Sanatorium   |  |  |  |  | d. STREET ADDRESS<br>1 HAGERSTOWN RD. S   |  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  |  |  |  | 4. DATE OF DEATH  |  |  |  |  | 5. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |
| First Middle Last<br>Julia M. Wierdebaugh   |  |  |  |  | Month Day Year<br>December 25 1965  |  |  |  |  |   |  |  |  |  |
| 5. SEX<br>F   |  |  |  |  | 6. COLOR OR RACE<br>White   |  |  |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |
| 8. DATE OF BIRTH<br>July 18, 1886   |  |  |  |  | 9. AGE (In years last birthday)<br>79 yrs.  |  |  |  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSE WIFE & GETTYSBURG SHOE   |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>FACTORY  |  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Wolfsville, Md.  |  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  | 13. FATHER'S NAME<br>George Parks   |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br>Amanda Dith Wolf  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>no   |  |  |  |  | 16. SOCIAL SECURITY NO.<br>194-26-6176  |  |  |  |  | 17. INFORMANT<br>Mrs. George Mills Hagerstown, Md.  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>4201<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) Coronary Atherosclerosis<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>None |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>4 hrs<br>20 yrs   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |   |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19   |  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |  |
| 20f. (City or town)   |  |  |  |  | 20g. (County)   |  |  |  |  | 20h. (State)  |  |  |  |  |
| 21. I certify that (if this hospital) attended the deceased from Aug 24, 1964, to Dec 25, 1965, that (I/We) last saw the deceased alive on Dec 10, 1965, and that death occurred at 12:30 M, from the causes and on the date stated above.  |  |  |  |  |   |  |  |  |  | 22b. DATE SIGNED<br>12-25-65  |  |  |  |  |
| 22a. SIGNATURE<br>M.E. Byrkit   |  |  |  |  | 22c. PHYSICIAN'S NAME (Type)<br>M.E. Byrkit   |  |  |  |  | 22d. ADDRESS<br>Williamsport Md.  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  |  |  |  | 23b. DATE THEREOF<br>12/28/65   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Burns Hill  |  |  |  |  |
| 23d. LOCATION (City, town or county)<br>Hagerstown  |  |  |  |  | 23e. (State)<br>Md.   |  |  |  |  | 23f. (Country)<br>U.S.A.  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Charles J. Gave   |  |  |  |  | 24a. ADDRESS<br>Hagerstown  |  |  |  |  | 24b. REC'D BY REGISTRAR<br>DEC 29 1965  |  |  |  |  |
| 24c. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |  | 24d. (City, town or county)<br>Hagerstown   |  |  |  |  | 24e. (State)<br>Md.   |  |  |  |  |



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TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 6 to be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>14</div> <div>M</div> <div>90</div> <div>I</div> <div>0</div>  |  |   |  |   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|---|--|---|--|--|--|--|--|---|--|
| <div>1</div> <div>17099</div> <div>20481</div>  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div>   |  |   |  |   |  |   |  |  |  |  |  |   |  |
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Washington</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Avalon Manor Nursing Home</u>   |  |   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u><br>d. STREET ADDRESS <u>1</u> |  |  |  |  |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Sarah F. Wetherall</u>   |  |   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>December</u> Day <u>13</u> Year <u>19 65</u>  |  |  |  |  |  |   |  |
| <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>November 1, 1880</u>  |  | <b>9. AGE (In years last birthday)</b><br><u>85 yrs.</u>                               |  | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u>              |  | <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Real Estate</u>  |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>  </u>   |  |   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Washington, D. C.</u> |  |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>      |  |
| <b>13. FATHER'S NAME</b><br><u>John W. Wetherall</u>  |  |   |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Ella J. Stanford</u>  |  |  |  |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>  |  |   |  | <b>16. SOCIAL SECURITY NO.</b> (If yes give number or date of service) <u>  </u>  |  | <b>17. INFORMANT</b><br><u>John H. Bowie</u> Address <u>811 Rolling Road Hagerstown</u>   |  |  |  |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br><u>447X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive Vascular Disease</u><br>DUE TO (c) <u>Arteriosclerosis - Generalized</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Abscess left hip</u> |  |   |  |   |  |   |  |  |  |  |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year <u>19 65</u><br>Hour a.m. <u>  </u> p.m. <u>  </u>   |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>   |  | <b>20f. (City or town)</b> <u>  </u>   |  | <b>(County)</b> <u>  </u>  |  | <b>(State)</b> <u>  </u>                                  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 1961</u> , <b>to</b> <u>Dec. 13, 1965</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec. 13, 1965</u> , <b>and that death occurred at</b> <u>11:25 A.M.</u> , <b>from the causes and on the date stated above.</b>  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Ronald A. Hoffman</u> M.D.  |  |   |  |   |  | <b>22b. DATE SIGNED</b><br><u>14/12/65</u>  |  |  |  |  |  |   |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Lloyd A. Hoffman</u>  |  |   |  |   |  | <b>22d. ADDRESS</b><br><u>214 N. Potomac St. Hagerstown, Md.</u>  |  |  |  |  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |  |   |  | <b>23b. DATE THEREOF</b><br><u>12-15-65</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Oak Hill Cemetery</u>   |  |  |  | <b>23d. LOCATION (City, town or county)</b><br><u>Washington D. C.</u> |  |   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Wilhelm Funeral Home</u>  |  |   |  |   |  | <b>ADDRESS</b><br><u>4308 Suitland Rd Suitland Maryland</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 17 1965</u>                                   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>John A. Judge</u>              |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>17100</span> <span>CERTIFICATE OF DEATH</span> <span>20482</span> </div>   |  |   |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>  |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>53 years</b>  |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington County Hospital</b>   |  |   |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>                                |   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>THOMAS</b> Middle <b>SCHLEIGH</b> Last <b>WHITE, SR.</b>  |  |   |  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>31</b> Year <b>1965</b>   |   |  |   |  |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>June 20, 1912</b>                                      |  | 9. AGE (In years last birthday) <b>53</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>custodian</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>board of educat.</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Hagerstown, Md.</b> |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>Frederick T. White</b>  |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Guessford</b>  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>WW II 214-09-6347</b>   |  | 17. INFORMANT<br><b>Edna S. White, Hagerstown, Md.</b>                        |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>4201 DUE TO (b) <b>Hypertensive CV Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) |  |   |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b><br><b>8 years</b>                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m. 19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> , 19 <b>57</b> , to <b>12-31</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12-29</b> 19 <b>65</b> , and that death occurred at <b>11<sup>00</sup></b> M, from the causes and on the date stated above.                |  |   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Robert P. Conrad</b>   |  |   |  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |  | 22b. DATE SIGNED<br><b>1-3-66</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert P. Conrad</b>   |  |   |  |   | 22d. ADDRESS<br><b>132 W. Washington Hagerstown, Md.</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |  | 23b. DATE THEREOF<br><b>1-4-66</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Hagerstown, Md.</b>        |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>  |  |   |  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 6 1966</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |   |  |



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DEPARTMENT OF HEALTH

Washington

Washington

23 years

Washington

Washington County Hospital

Washington

1912-1913  
June 20, 1912

State of Illinois, Washington Co.

Washington Co. Illinois

1912-1913  
June 20, 1912

Washington Co. Illinois  
June 20, 1912

1912-1913  
June 20, 1912

Washington Co. Illinois  
June 20, 1912

1912-1913  
June 20, 1912

Washington Co. Illinois  
June 20, 1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |   |   |   |  |   |  |
|--|--|--|--|---|---|---|--|---|--|
| 17101  |  |  |  |   | 20483   |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |  |  | c. LENGTH OF STAY IN 1b<br><u>58 yrs.</u>                                |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>03 Hagerstown</u>                                      |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Washington County Hospital</u>  |  |  |  |   | d. STREET ADDRESS<br><u>121 N. Locust St.</u>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Anna</u> Middle <u>May</u> Last <u>Whitmer</u>  |  |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>21</u> Year <u>1965</u> |   |   |   |  |   |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>May 31, 1906</u>                               |  | 9. AGE (In years last birthday)<br><u>59</u> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Seamstress</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Furniture Mfg.</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>New York City</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                            |  |   |  |
| 13. FATHER'S NAME<br><u>Thomas J. Gallagher</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Eva Morgan</u>   |   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>214-09-4546</u>  |  | 17. INFORMANT<br><u>Mrs. Eva Beitler</u>  |   | Address <u>Hagerstown, Md.</u><br><u>121 E. Franklin St.</u>          |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cachexia</u><br><u>151X</u> DUE TO <u>Adeno. Carcinoma of stomach</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 wks</u><br><u>3 mo</u>                                   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-7</u> , 19 <u>65</u> to <u>death</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-20</u> , 19 <u>65</u> , and that death occurred at <u>11:55 AM</u> from the causes and on the date stated above.   |  |  |  |   |   |   |  |   |  |
| 22a. SIGNATURE<br><u>R F Keadle</u>  |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |   | 22b. DATE SIGNED<br><u>12-21-65</u>                                   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Robert F. Keadle</u>  |  |  |  | 22d. ADDRESS<br><u>Hagerstown Md</u>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>12/23/65</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rest Haven Cemetery</u>  |   | 23d. LOCATION (City, town or county) (State)<br><u>Hagerstown Md.</u> |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Wm. C. Horst</u>  |  |  |  | ADDRESS<br><u>Rest Haven Funeral Chapel Hagerstown, Md.</u>   |   | 25a. REC'D BY REGISTRAR<br><u>DEC 27 1965</u>                         |  |   |  |
|  |  |  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                    |  |   |  |

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Department of Health  
Washington, D.C.  
20001  
Mr. J. Edgar Hoover  
Director  
Federal Bureau of Investigation  
Washington, D.C.  
20535  
Dear Mr. Hoover:

Enclosed for you are  
three copies of a letter  
headings

12-2-60  
R.F. Keable  
Robert F. Keable  
12-2-60  
W.C. Keable  
W.C. Keable



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 5-63

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                             |                                    |   |  |   |  |  |   |   |  |
|---|--|-----------------------------|------------------------------------|---|--|---|--|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                             |                                    |   |  |   |  |  |   |   |  |
| 17102   |  |                             |                                    |   |  |   |  |  |   |   |  |
| 20484   |  |                             |                                    |   |  |   |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Washington MARYLAND   |  |                             |                                    |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE Maryland b. COUNTY Washington |  |  |   |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Hagerstown Md.  |  |                             |                                    | c. LENGTH OF STAY IN 1b<br>43 yrs   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Hagerstown Maryland                         |  |  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Washington County Hospital  |  |                             |                                    |   |  | d. STREET ADDRESS<br>655 Forrest Dr.  |  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Kenneth   |  |                             | First Middle Last<br>Hall Williams |   |  | 4. DATE OF DEATH<br>Dec 10 19 65  |  |  | Month Day Year                              |   |  |
| 5. SEX<br>Male  |  | 6. COLOR OR RACE<br>Colored |                                    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>April 26 1901   |  | 9. AGE (In years last birthday)<br>64 yrs                      |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Railroad   |  |                             |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br>Fort Frederick, Md.  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>USA.   |  |  | 12. CITIZEN OF WHAT COUNTRY?                |   |  |
| 13. FATHER'S NAME<br>Charles A. Williams  |  |                             |                                    |   |  | 14. MOTHER'S MAIDEN NAME<br>Bertha Hall   |  |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>no   |  |                             |                                    | 16. SOCIAL SECURITY NO.<br>214-09-7290  |  | 17. INFORMANT<br>Mrs. Elva H. Williams 655 Forrest Dr   |  |  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4201 Coronary occlusion<br>DUE TO (b) Arterio sclerotic heart disease<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>Hypertension. Chronic nephritis.   |  |                             |                                    |   |  |   |  |  |   |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                             |                                    |   |  |   |  |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour e.m. p.m. 19<br>20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |                             |                                    |   |  |   |  |  |   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from July 1965 to Dec 10, 1965 that (I) (we) last saw the deceased alive on Dec 10, 1965, and that death occurred at 6:25 PM, from the causes and on the date stated above.  |  |                             |                                    |   |  |   |  |  |   |   |  |
| 22a. SIGNATURE<br>Eldon S. Hochstetler M.D.   |  |                             |                                    |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22b. DATE SIGNED<br>12/11/65                |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>Eldon S. Hochstetler  |  |                             |                                    |   |  | 22d. ADDRESS<br>Hagerstown, Md.   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |                             | 23b. DATE THEREOF<br>Dec 14 1965   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Rose Hill Cemetery |   |  | 23d. LOCATION (City, town or county) (State)<br>Hagerstown Md. |   |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>John R. Watson Jr. Hagerstown Md.   |  |                             |                                    |   |  | 25a. REC'D BY REGISTRAR<br>DEC 16 1965  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |   |  |

11102

11102

WASHINGTON, D.C. 20540  
OFFICE OF THE ATTORNEY GENERAL  
UNITED STATES DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20530  
JAN 11 1961  
MEMORANDUM FOR THE ATTORNEY GENERAL  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or letter, possibly dated January 11, 1961, addressed to the Attorney General. The subject line is also illegible. The body of the text contains several paragraphs of text, but the words are too light to transcribe accurately. There are some words that are more legible, such as "WASHINGTON, D.C.", "OFFICE OF THE ATTORNEY GENERAL", "UNITED STATES DEPARTMENT OF JUSTICE", "JAN 11 1961", "MEMORANDUM FOR THE ATTORNEY GENERAL", and "SUBJECT:". The text continues with several lines of illegible text, followed by a signature block and a date "DEC 11 1960".]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |   |  |  |   |  |
|--|--|--|--|---|--|---|---|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |   |  |   |   |  |  |   |  |
| 17103  |  |  |  |   |  |   |   |  |  |   |  |
| 20485  |  |  |  |   |  |   |   |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  |  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |   |  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |  |  |  | c. LENGTH OF STAY IN 1b<br><u>13 days</u>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>13 Hagerstown</u>                                      |   |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Washington County Hospital</u>  |  |  |  |   |  | d. STREET ADDRESS<br><u>735 Dale Street</u>   |   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Elmer</u> Middle <u>Elsworth</u> Last <u>Wolfe</u>   |  |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>28</u> Year <u>1965</u> |   |  |   |   |  |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Aug. 31-1887</u>   |   | 9. AGE (In years last birthday)<br><u>78</u> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>3</u> Days <u>26</u> Hours <u></u> Min. <u></u>     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Roofer</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Roofing</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u> |   |  |
| 13. FATHER'S NAME<br><u>David Wolfe</u>  |  |  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Emma Flora</u>   |   |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  |  |  | 16. SOCIAL SECURITY NO.<br><u>220 50 6794</u>   |  | 17. INFORMANT <u>735 Dale St.</u><br><u>Mrs. Della Bond Hagerstown Md.</u>  |   |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u><br><u>9049</u> DUE TO (b) <u>Thrombophlebitis Left Lower Extremity</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Fracture &amp; Contusion of Left Hip</u> |  |  |  |   |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr ±</u><br><u>13 days</u><br><u>13 days</u>             |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |  |   |  |   |   |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a.m.</u> <u>p.m.</u> <u>19</u>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)               |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> , 19 <u>65</u> , to <u>12/28</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>65</u> , and that death occurred at <u>2 p.m.</u> , from the causes and on the date stated above.   |  |  |  |   |  |   |   |  |  |   |  |
| 22a. SIGNATURE<br><u>Frank F. Shupp</u>  |  |  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |   | 22b. DATE SIGNED<br><u>12/29/65</u>                |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Frank F. Shupp M.D.</u>   |  |  |  |   |  | 22d. ADDRESS<br><u>109 1/2 N. Potomac St. Hagerstown Md.</u>  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>Dec. 31-65</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rose Hill Cemetery</u>   |  |   | 23d. LOCATION (City, town or county) (State)<br><u>Hagerstown Md.</u> |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Albert L. Leaf Williamsport Maryland</u>  |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br><u>JAN 3 1966</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |   |  |

MEDICAL CERTIFICATION

1968

Continuation of Data

1968

1968  
The number of birds  
seen at the site of the  
nest was 15 birds.

1968  
The number of birds  
seen at the site of the  
nest was 15 birds.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20486

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u><br>c. LENGTH OF STAY IN 1b <u>30 yrs.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u><br>d. STREET ADDRESS <u>606 Sunset Ave.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Pearl</u> Middle <u>Edith</u> Last <u>Wood</u>   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>23</u> Year <u>19 65</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>December 3, 1886</u>   |
| 9. AGE (In years last birthday) <u>79</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Rileyville, Va.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Isaac Henry Gochenour</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Mortha Shaffer</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT <u>Mr. Harry L. Wood</u>   |  | Address <u>606 Sunset Ave. Hagerstown, Md.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolus - Secondary</u><br>9035<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <u>to Intertrochanteric Fracture</u><br>DUE TO (c) <u>Left Femur</u>   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 hr - 9 days</u>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br><u>Fell on street - After bumping into person by</u>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>22 Dec 14 19 65</u><br>Hour a.m. p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Street</u>  | 20f. (City or town) (County) (State)<br><u>Hagerstown Wash Md</u>                              |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>Edward W. Ditto III</u>  |  | 22. DATE SIGNED <u>12-28-65</u>  |  |
| EXAMINER'S NAME (Type) <u>Edward W. Ditto, III</u>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>12/26/65</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>Hagerstown Md.</u>  |  |
| 24. FUNERAL DIRECTOR <u>Wm. C. Hanks</u>   |  | 25. REC'D BY REGISTRAR <u>DEC 28 1965</u>  |  |
| Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

30 yrs.

Wm. C. Miller



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |                                  |  |  |   |  |   |  |
|---|--|-------------------------------|----------------------------------|--|--|---|--|---|--|
| 17105 <span style="float: right;">20487</span>  |  |                               |                                  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. CDUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b <b>5 1/2 YRS.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b> |  |                               |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. CDUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>d. STREET ADDRESS <b>1108 ORCHARD HILLS PKWY.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROSE MARY</b> Middle <b>PATRICIA</b> Last <b>WRAGA</b>  |  |                               |                                  |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>2</b> Year <b>1965</b>  |   |  |   |  |
| 5. SEX <b>FEMALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b> |                                  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>3/17/1924</b>   |  | 9. AGE (In years last birthday) <b>41</b><br>IF UNDER 1 YEAR: Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b><br>IF UNDER 24 HRS. <b>1</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BRIDAL CONSULTANT</b>  |  |                               |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>LADIES APPAREL</b>  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>NEW JERSEY</b>   |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>MICHAEL P. GIORDANO</b>  |  |                               |                                  |  | 14. MOTHER'S MAIDEN NAME <b>MARY COREALO</b>   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)   |  |                               |                                  | 16. SOCIAL SECURITY NO. <b>139-12-5063</b>   |  | 17. INFORMANT <b>MR. WALTER W. WRAGA</b> Address <b>HAGERSTOWN MD.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lymphosarcoma</b><br>2001 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)                              |  |                               |                                  |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>3-4 mo</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Metastases to Liver, Spleen, Lymph Nodes.</b>  |  |                               |                                  |  |  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  |                               |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                               |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>25 Nov 1965</b> to <b>1 Dec 1965</b> , that (I) (we) last saw the deceased alive on <b>1 Dec 1965</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.  |  |                               |                                  |  |  |   |  |   |  |
| 22a. SIGNATURE <b>Richard T. Binford</b>  |  |                               |                                  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED <b>12/3/65</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>DR RICHARD T. BINFORD</b>   |  |                               |                                  |  |  | 22d. ADDRESS <b>1135 POTOMAC AVE. HAGERSTOWN, MD.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |                               | 23b. DATE THEREOF <b>12/4/65</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>  |   | 23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b> |   |  |
| 24. FUNERAL DIRECTOR <b>W. J. Norment, Hagerstown, Md.</b>  |  |                               |                                  |  |  | 25a. REC'D BY REGISTRAR <b>DEC 7 1965</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |

50185

WASHINGTON

WASHINGTON

25 JAN 1962

WASHINGTON

1100 OCEANOGRAPHIC

WASHINGTON COAST GUARD

60

WASHINGTON

WAGA

WASHINGTON

HOOD RIVER

3/12/62

TRUCK / WHITE

U.S.A.

THE TRUCK

INDICATED

FEDERAL COAST GUARD

MARY CORP

WASHINGTON

WASHINGTON

139-1-10034-1 WAGA

*Handwritten signature*

*Handwritten note: 139-1-10034-1 WAGA*

*Handwritten note: 139-1-10034-1 WAGA*

*Handwritten signature*

100

WASHINGTON

HOOD RIVER

12/1/62

WAGA

DEC 1962

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |  |  |  |  |  |   |  |  |  |
|--|--|-------------------------------|--|--|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |  |  |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |                               |  |  |  |  |  |   |  |  |  |
| 17106 20488  |  |                               |  |  |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN lb <b>1 DAY</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>   |  |                               |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>d. STREET ADDRESS <b>330 MITCHELL AVENUE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>HELEN LOUISE ZEGER</b>   |  |                               |  |  |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>1</b> Year <b>1965</b>  |  |   |  |  |  |
| 5. SEX <b>FEMALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 8. DATE OF BIRTH <b>SEPT. 15, 1910</b>   |  | 9. AGE (In years last birthday) <b>55</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>WILLIAM N. BARRON</b>   |  |                               |  |  |  | 14. MOTHER'S MAIDEN NAME <b>CHARLOTTE M. MAY HAGERSTOWN, MD.</b>   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |                               |  | 16. SOCIAL SECURITY NO. <b>NONE</b>  |  | 17. INFORMANT <b>ROY M. ZEGER 330 MITCHELL AVE.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br>4222 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Myocardial insufficiency</b><br>(a), stating the underlying cause last. DUE TO <b>Transition</b><br>(c) <b>Psychosis</b> |  |                               |  |  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>11 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis</b>   |  |                               |  |  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   |  |                               |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Oct 30, 1965</b> to <b>Dec 1, 1965</b> , that (I) (we) last saw the deceased alive on <b>Dec 1, 1965</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.   |  |                               |  |  |  |  |  |   |  |  |  |
| 22a. SIGNATURE <b>Louis G. Graff</b>   |  |                               |  |  |  | M.D. <b>LOUIS G. GRAFF M.D.</b>  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED <b>DEC. 2, 1965</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>LOUIS G. GRAFF M.D.</b>  |  |                               |  |  |  | 22d. ADDRESS <b>580 NORTHERN AVENUE HAGERSTOWN, MD.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  |                               |  | 23b. DATE THEREOF <b>DEC. 4, 1965</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>   |  | 23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles M. Rouse</b>   |  |                               |  |  |  | ADDRESS <b>HAGERSTOWN, MARYLAND</b>  |  | 25a. REC'D BY REGISTRAR <b>DEC 6 1965</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

15100

20100

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

1 DAY

WASHINGTON

WASHINGTON COUNTY HOSPITAL

300 MITCHELL AVENUE

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

SEPT. 12, 1910

WASHINGTON

OWN HOME

WASHINGTON

WASHINGTON CO., MARYLAND

CHARLOTTE A. DAY

WILLIAM N. BARNES

300 MITCHELL AVE.

HOME

NO

*[Faint handwritten notes and signatures]*

DEC. 2, 1912

300 MITCHELL AVENUE, WASHINGTON, MD.

LOUIS A. GRANT, M.D.

WASHINGTON, MARYLAND

DEC. 2, 1912

WILLIAM

WASHINGTON, MARYLAND DEC 2 1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17107  
CERTIFICATE OF DEATH  
20489

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Washington MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown<br>c. LENGTH OF STAY IN ID 2 days<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital  |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Washington<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport<br>d. STREET ADDRESS 207 S. Conococheague St.<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) Mabel Devonah Zimmerman<br>First Middle Last   |  | 4. DATE OF DEATH Dec 8 19 65<br>Month Day Year   |   |
| 5. SEX Female   | 6. COLOR OR RACE White   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH Aug. 1 1903<br>9. AGE (In years last birthday) 62 yrs.<br>IF UNDER 1 YEAR Months 4 Days 7<br>IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roller Up   |  | 10b. KIND OF BUSINESS OR INDUSTRY Ribbon Co.   | 11. BIRTHPLACE (County & State, or foreign country) Williamsport Md.<br>12. CITIZEN OF WHAT COUNTRY? U.S.A.                               |
| 13. FATHER'S NAME Otho Cottrill   |  | 14. MOTHER'S MAIDEN NAME Bessie Lindsay  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No<br>(If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO. 216 05 6301<br>17. INFORMANT Mr. William Zimmerman Williamsport Md.<br>Address 207 S. Conococheague St.  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4672 brain swelling<br>DUE TO (b) intracerebral hemorrhage<br>DUE TO (c) vascular malformation<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) unknown<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) aspiration pneumonia<br>INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 6, 1965, to Dec 8, 1965, that (I) (we) last saw the deceased alive on Dec 8, 1965, and that death occurred at M, from the causes and on the date stated above.  |  |  |   |
| 22a. SIGNATURE John C. Stouffer   |  | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type) John C. Stouffer   |  | 22d. ADDRESS Hagerstown, Md.<br>M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  | 23b. DATE THEREOF Dec. 11-65   | 23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery  | 23d. LOCATION (City, town or county) (State) Williamsport Md.   |
| 24. FUNERAL DIRECTOR Mr. Albert L. Leaf Williamsport Md.  |  | 25a. REC'D BY REGISTRAR DATE DEC 13 1965<br>25b. REGISTRAR'S SIGNATURE Charles Judge   |   |

2010

1110

1 day  
2 days  
3 days

has really  
interest in  
research  
computer graphics

1988 11 22

John H. H.  
1988 11 22

DEC 1 1988